



# House of Representatives

## File No. 718

General Assembly

January Session, 2021

**(Reprint of File No. 338)**

Substitute House Bill No. 6391  
As Amended by House Amendment  
Schedule "A"

Approved by the Legislative Commissioner  
May 24, 2021

**AN ACT CONCERNING THE INSURANCE DEPARTMENT'S  
RECOMMENDATIONS REGARDING THE GENERAL STATUTES.**

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

1 Section 1. Subsections (b) and (c) of section 19a-7p of the general  
2 statutes are repealed and the following is substituted in lieu thereof  
3 (*Effective July 1, 2021*):

4 (b) (1) As used in this section: (A) "Health insurance" means health  
5 insurance of the types specified in subdivisions (1), (2), (4), (11) and (12)  
6 of section 38a-469; and (B) "health care center" has the same meaning as  
7 provided in section 38a-175.

8 (2) Each domestic insurer or domestic health care center doing health  
9 insurance business in this state shall annually pay to the Insurance  
10 Commissioner, for deposit in the Insurance Fund established under  
11 section 38a-52a, a public health fee assessed by the Insurance  
12 Commissioner pursuant to this section.

13 (3) (A) Not later than September first, annually, each such insurer or  
14 health care center shall report to the Insurance Commissioner, in the  
15 form and manner prescribed by [said] the commissioner, the number of  
16 insured or enrolled lives in this state as of May first immediately  
17 preceding the date for which such insurer or health care center is  
18 providing health insurance that provides coverage of the types specified  
19 in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Such number  
20 shall not include lives enrolled in Medicare, any medical assistance  
21 program administered by the Department of Social Services, workers'  
22 compensation insurance or Medicare Part C plans. The commissioner  
23 may require each such insurer or health care center or any other person  
24 to submit to the commissioner any records that are in such insurer's,  
25 health care center's or other person's possession if such records were  
26 used to prepare such insurer's or health care center's annual report  
27 submitted pursuant to this subparagraph.

28 (B) Each such insurer or health care center that fails to timely submit  
29 an annual report pursuant to subparagraph (A) of this subdivision shall  
30 pay to the Insurance Commissioner, in the form and manner prescribed  
31 by the commissioner, a late filing fee of one hundred dollars per day for  
32 each day from the date that the annual report was due.

33 (C) If the Insurance Commissioner determines that there is a  
34 discrepancy, other than a good faith discrepancy, between the number  
35 of insured or enrolled lives that the insurer or health care center  
36 reported to the commissioner pursuant to subparagraph (A) of this  
37 subdivision and the number of such lives that the insurer or health care  
38 center should have reported to the commissioner pursuant to said  
39 subparagraph (A), the insurer or health care center shall be liable for a  
40 civil penalty of not more than fifteen thousand dollars.

41 (c) Not later than November first, annually, the Insurance  
42 Commissioner shall determine the fee to be assessed for the current  
43 fiscal year against each such insurer and health care center. Such fee  
44 shall be calculated by multiplying the number of lives reported to said  
45 commissioner pursuant to subparagraph (A) of subdivision (3) of

46 subsection (b) of this section by a factor, determined annually by said  
47 commissioner as set forth in this subsection, to fully fund the aggregate  
48 amount determined under subsection (a) of this section. The Insurance  
49 Commissioner shall determine the factor by dividing the aggregate  
50 amount by the total number of lives reported to said commissioner  
51 pursuant to subparagraph (A) of subdivision (3) of subsection (b) of this  
52 section.

53 Sec. 2. Section 38a-12 of the general statutes is repealed and the  
54 following is substituted in lieu thereof (*Effective from passage*):

55 [(a)] The commissioner shall, annually, submit to the Governor a  
56 report of the commissioner's official acts and of the condition of all  
57 insurance companies doing business in this state, with a condensed  
58 statement of their reports made to the commissioner or accepted by the  
59 commissioner, together with an abstract of all accounts rendered to any  
60 court by any receiver of a domestic insurance company, a statement of  
61 the fees received by the commissioner and paid by the commissioner to  
62 the Treasurer and such other facts as are required by law.

63 [(b) On or before January fifteenth annually, the commissioner shall  
64 submit to the joint standing committee of the General Assembly having  
65 cognizance of matters relating to insurance a report, in accordance with  
66 the provisions of section 11-4a, detailing all the information the  
67 commissioner received during the past year pursuant to sections 29-311,  
68 31-290d, 38a-356 and 53-445.]

69 Sec. 3. Subsections (b) to (g), inclusive, of section 38a-38 of the general  
70 statutes are repealed and the following is substituted in lieu thereof  
71 (*Effective from passage*):

72 (b) Definitions. For the purposes of this section:

73 (1) "Authorized individual" means an individual who is known to,  
74 and screened by, a licensee, and who is determined to be necessary and  
75 appropriate to have access to the nonpublic information that is held by  
76 the licensee and on such licensee's information systems.

77 (2) "Consumer" means an individual, including, but not limited to, an  
78 applicant, beneficiary, certificate holder, claimant, insured or  
79 policyholder, who is a resident of this state and whose nonpublic  
80 information is in a licensee's possession, custody or control.

81 (3) "Cybersecurity event" means an event resulting in any  
82 unauthorized access to, or disruption or misuse of, an information  
83 system or the nonpublic information stored thereon, except if: (A) The  
84 event involves the unauthorized acquisition of encrypted nonpublic  
85 information if the encryption process for such information or encryption  
86 key to such information is not acquired, released or used without  
87 authorization; or (B) the event involves access of nonpublic information  
88 by an unauthorized person and the licensee determines that such  
89 information has not been used or released and has been returned or  
90 destroyed.

91 (4) "Encryption" means the transformation of data or information into  
92 a form that results in a low probability of assigning meaning to such  
93 data or information without the use of a protective process or key.

94 (5) "Information security program" means the administrative,  
95 technical and physical safeguards that a licensee uses to access, collect,  
96 distribute, process, protect, store, use, transmit, dispose of or otherwise  
97 handle nonpublic information.

98 (6) "Information system" means a discrete set of electronic  
99 information resources organized for the collection, processing,  
100 maintenance, use, sharing, dissemination or disposition of nonpublic  
101 electronic data or information, as well as any specialized system such as  
102 an industrial or process controls system, telephone switching and  
103 private branch exchange system, and environmental control system.

104 (7) "Licensee" means any person licensed, authorized to operate or  
105 registered, or required to be licensed, authorized to operate or  
106 registered, pursuant to the insurance laws of this state, [except for]  
107 including, but not limited to, a fraternal benefit society, an interlocal risk  
108 management agency formed pursuant to chapter 113a or an employers'

109 mutual association authorized under part C of chapter 568, but not  
110 including a purchasing group or [a] risk retention group chartered and  
111 licensed in another state, [or] a [licensee that is] person acting as an  
112 assuming insurer and domiciled in another state or jurisdiction or a  
113 commissioner of the Superior Court acting as a title agent, as defined in  
114 section 38a-402.

115 (8) "Multifactor authentication" means authentication through  
116 verification of at least two of the following types of authentication  
117 factors: (A) A knowledge factor, including, but not limited to, a  
118 password; (B) a possession factor, including, but not limited to, a token  
119 or text message on a mobile phone; or (C) an inheritance factor,  
120 including, but not limited to, a biometric characteristic.

121 (9) "Nonpublic information" means electronic data and information,  
122 other than publicly available information and [information concerning]  
123 a consumer's age or gender, that: (A) Concerns the business of a licensee  
124 and that, if accessed, disclosed, tampered with or used without  
125 authorization from the licensee, would have a material adverse impact  
126 on the business, operations or security of such licensee; (B) concerns a  
127 consumer and that, because such data or information contains a name,  
128 number, personal mark or other identifier, can be used to identify such  
129 consumer in combination with: (i) A Social Security number; (ii) a  
130 driver's license number or nondriver identification card number; (iii) an  
131 account, credit or debit card number; (iv) an access or security code, or  
132 a password, that would permit access to the consumer's financial  
133 account; or (v) a biometric record; or (C) is in a form or medium created  
134 by, or derived from, a health care provider or consumer and concerns:  
135 (i) The past, present or future physical, mental or behavioral health or  
136 condition of a consumer or a member of a consumer's family; (ii) the  
137 provision of health care to a consumer; or (iii) payment for the provision  
138 of health care to a consumer.

139 (10) "Person" means any individual or any nongovernmental entity,  
140 including, but not limited to, any nongovernmental partnership,  
141 corporation, branch, agency or association.

142 (11) "Publicly available information" means data or information that:  
143 (A) (i) Must be disclosed to the general public pursuant to applicable  
144 law; or (ii) may be made available to the general public from  
145 government records or widely distributed media; and (B) a licensee  
146 reasonably believes, after investigation: (i) Is of a type that is available  
147 to the general public; and (ii) the consumer has not directed to be  
148 withheld from the general public, if the consumer may direct that such  
149 data or information be withheld from the general public pursuant to  
150 applicable law.

151 (12) "Risk assessment" means the risk assessment that each licensee is  
152 required to conduct pursuant to subdivision (3) of subsection (c) of this  
153 section.

154 (13) "Third-party service provider" means a person, other than a  
155 licensee, that: (A) Contracts with a licensee to maintain, process or store  
156 nonpublic information; or (B) is otherwise permitted to access nonpublic  
157 information through the person's provision of services to a licensee.

158 (c) Information Security Program. (1) Implementation of an  
159 information security program. Except as provided in subdivision (10) of  
160 this subsection, each licensee shall, not later than October 1, [2020] 2021,  
161 develop, implement and maintain a comprehensive written information  
162 security program that is based on the licensee's risk assessment and  
163 contains the administrative, technical and physical safeguards for the  
164 protection of nonpublic information and such licensee's information  
165 systems. Each information security program shall be commensurate  
166 with the size and complexity of the licensee, the nature and scope of the  
167 licensee's activities, including, but not limited to, such licensee's use of  
168 third-party service providers, and the sensitivity of the nonpublic  
169 information used by such licensee or in such licensee's possession,  
170 custody or control.

171 (2) Objectives of Information Security Program. Except as provided  
172 in subdivision (10) of this subsection, each information security  
173 program developed, implemented and maintained by a licensee

174 pursuant to subdivision (1) of this subsection shall:

175 (A) Be designed to:

176 (i) Protect the security and confidentiality of the nonpublic  
177 information and the security of the information system;

178 (ii) Protect against all threats and hazards to the security or integrity  
179 of nonpublic information and the information system; and

180 (iii) Protect against unauthorized access to, or use of, nonpublic  
181 information and minimize the likelihood of harm to any consumer; and

182 (B) Define, and periodically reevaluate, a schedule for retention of  
183 nonpublic information and a mechanism for the destruction of such  
184 information when such information no longer is needed.

185 (3) Risk Assessment. Except as provided in subdivision (10) of this  
186 subsection, each licensee shall:

187 (A) Designate one or more employees, an affiliate or an outside  
188 vendor designated to act on behalf of such licensee as the person  
189 responsible for such licensee's information security program;

190 (B) Identify reasonably foreseeable internal or external threats that  
191 could result in unauthorized access, transmission, disclosure, misuse,  
192 alteration or destruction of nonpublic information, including, but not  
193 limited to, the security of information systems that are, and nonpublic  
194 information that is, accessible to, or held by, third-party service  
195 providers;

196 (C) Assess the likelihood and potential damage of the threats  
197 identified pursuant to subparagraph (B) of this subdivision, taking into  
198 consideration the sensitivity of the nonpublic information;

199 (D) Assess the sufficiency of policies, procedures, information  
200 systems and other safeguards in place to manage the threats identified  
201 pursuant to subparagraph (B) of this subdivision by considering such

202 threats in the following areas of such licensee's operations:

203 (i) Employee training and management;

204 (ii) Information systems, including, but not limited to, network and  
205 software design, as well as information classification, governance,  
206 processing, storage, transmission and disposal; and

207 (iii) Detection, prevention and response to attacks, intrusions or other  
208 systems failures;

209 (E) Implement information safeguards to manage the threats  
210 identified in such licensee's ongoing assessment; and

211 (F) Not less than annually, assess the effectiveness of such licensee's  
212 safeguards' key controls, systems and procedures.

213 (4) Risk Management. Except as provided in subdivision (10) of this  
214 subsection, each licensee shall, based on such licensee's risk assessment:

215 (A) Design such licensee's information security program to mitigate  
216 the identified risks, commensurate with the size and complexity of such  
217 licensee's activities, including, but not limited to, such licensee's use of  
218 third-party service providers, and the sensitivity of the nonpublic  
219 information used by such licensee or in such licensee's possession,  
220 custody or control.

221 (B) Determine which of the following security measures are  
222 appropriate and, if such measures are appropriate, implement such  
223 measures:

224 (i) Placement of access controls on such licensee's information  
225 systems, including, but not limited to, controls to authenticate and  
226 restrict access only to authorized individuals to protect against the  
227 unauthorized acquisition of nonpublic information;

228 (ii) Identification and management of the data, personnel, devices,  
229 systems and facilities that enable such licensee to achieve such licensee's



230 business purposes in accordance with their relative importance to such  
231 licensee's business objectives and risk strategy;

232 (iii) Restriction of access to physical locations containing nonpublic  
233 information only to authorized individuals;

234 (iv) Protection, by encryption or other appropriate means, of all  
235 nonpublic information while such information is transmitted over an  
236 external network or stored on a laptop computer or other portable  
237 computing or storage device or medium;

238 (v) Adoption of secure development practices for in-house developed  
239 applications utilized by such licensee and procedures for evaluating,  
240 assessing or testing the security of externally developed applications  
241 utilized by such licensee;

242 (vi) Modification of such licensee's information system in accordance  
243 with such licensee's information security program;

244 (vii) Utilization of effective controls, which may include multifactor  
245 authentication procedures for any individual accessing nonpublic  
246 information;

247 (viii) Regular testing and monitoring of systems and procedures to  
248 detect actual and attempted attacks on, or intrusions into, information  
249 systems;

250 (ix) Inclusion of audit trails within the information security program  
251 that are designed to detect and respond to cybersecurity events, and  
252 designed to reconstruct material financial transactions sufficient to  
253 support the normal operations and obligations of the licensee;

254 (x) Implementation of measures to protect against the destruction,  
255 loss or damage of nonpublic information due to environmental hazards,  
256 including, but not limited to, fire and water, or other catastrophes or  
257 technological failures; and

258 (xi) Development, implementation and maintenance of procedures

259 for the secure disposal of nonpublic information in any format.

260 (C) Include cybersecurity risks in such licensee's enterprise risk  
261 management process.

262 (D) Stay informed regarding emerging threats or vulnerabilities and  
263 utilize reasonable security measures when sharing information relative  
264 to the character of the sharing and the type of information shared.

265 (E) Provide such licensee's personnel with cybersecurity awareness  
266 training that is updated as necessary to reflect risks identified by such  
267 licensee in such licensee's risk assessment.

268 (5) Oversight by Board of Directors. Except as provided in  
269 subdivision (10) of this subsection, if a licensee has a board of directors,  
270 the board, or an appropriate committee of such board, shall, at a  
271 minimum:

272 (A) Require the licensee's executive management or [its] such  
273 executive management's delegates to develop, implement and maintain  
274 such licensee's information security program.

275 (B) Require the licensee's executive management or [its] such  
276 executive management's delegates to report, in writing and at least  
277 annually, the following information:

278 (i) The overall status of such licensee's information security program  
279 and such licensee's compliance with this section; and

280 (ii) Material matters related to such licensee's information security  
281 program, addressing issues such as risk assessment, risk management  
282 and control decisions, third-party service provider arrangements,  
283 results of testing, cybersecurity events or violations and management's  
284 responses thereto, and recommendations for changes in such  
285 information security program.

286 (C) If a licensee's executive management delegates any of [its] such  
287 executive management's responsibilities under subparagraph (A) or (B)

288 of this subdivision, [it] such executive management shall oversee the  
289 development, implementation and maintenance of the licensee's  
290 information security program prepared by the delegate or delegates,  
291 and shall receive a report from such delegate or delegates that satisfies  
292 the requirements established in subparagraph (B) of this subdivision.

293 (6) Oversight of Third-Party Service Provider Arrangements. Except  
294 as provided in subdivision (10) of this subsection:

295 (A) Each licensee shall exercise due diligence in selecting such  
296 licensee's third-party service providers; and

297 (B) Not later than October 1, [2021] 2022, each licensee shall require  
298 each of such licensee's third-party service providers to implement  
299 appropriate administrative, technical and physical measures to protect  
300 and secure the information systems that are, and nonpublic information  
301 that is, accessible to, or held by, such licensee's third-party service  
302 providers.

303 (7) Program Adjustments. Except as provided in subdivision (10) of  
304 this subsection, each licensee shall monitor, evaluate and adjust, as  
305 appropriate, such licensee's information security program consistent  
306 with any relevant changes in technology, the sensitivity of [such  
307 licensee's] the nonpublic information in such licensee's possession,  
308 custody or control, internal or external threats to such information and  
309 such licensee's own changing business arrangements, including, but not  
310 limited to, changes stemming from mergers and acquisitions, alliances  
311 and joint ventures, outsourcing arrangements and changes to  
312 information systems.

313 (8) Incident Response Plan. (A) Except as provided in subdivision (10)  
314 of this subsection, each licensee shall, as part of such licensee's  
315 information security program, establish a written incident response  
316 plan that is designed to promptly respond to, and recover from, any  
317 cybersecurity event that compromises the confidentiality, integrity or  
318 availability of nonpublic information that is in such licensee's  
319 possession, custody or control, such licensee's information systems or

320 the continuing functionality of any aspect of such licensee's business or  
321 operations.

322 (B) Each incident response plan shall address the following areas:

323 (i) The internal process for responding to a cybersecurity event;

324 (ii) The goals of such incident response plan;

325 (iii) The definition of clear roles, responsibilities and levels of  
326 decision-making authority;

327 (iv) External and internal communications;

328 (v) Information sharing;

329 (vi) Identification of requirements for the remediation of any  
330 identified weaknesses in information systems and associated controls;

331 (vii) Documentation and reporting regarding cybersecurity events  
332 and related incident response activities; and

333 (viii) Evaluation and revision, as necessary, of such incident response  
334 plan following each cybersecurity event.

335 (9) Annual Certification to Commissioner of Domiciliary State.  
336 Except as provided in subdivision (10) of this subsection, each insurer,  
337 health care center or fraternal benefit society domiciled in this state shall  
338 submit to the Insurance Commissioner a written statement, not later  
339 than [February] April fifteenth, annually, certifying that such insurer,  
340 health care center or fraternal benefit society is in compliance with the  
341 requirements set forth in this subsection. [Each insurer shall] A domestic  
342 insurer, health care center or fraternal benefit society that is a member  
343 of an insurance holding company system, as defined in section 38a-129,  
344 may submit one statement to the Insurance Commissioner on behalf of  
345 other domestic insurers, health care centers or fraternal benefit societies  
346 that are members of the same insurance holding company system, not  
347 later than April fifteenth, annually, certifying that such domestic

348 members of the insurance holding company system are in compliance  
349 with the requirements set forth in this subsection. Each insurer, health  
350 care center or fraternal benefit society shall, either directly or through  
351 an affiliate, maintain, for examination by the Insurance Department, all  
352 records, schedules and data supporting each statement that such  
353 insurer, health care center or fraternal benefit society, or a member of an  
354 insurance holding company system acting on behalf of such insurer,  
355 health care center or fraternal benefit society, submits to the  
356 commissioner for a period of five years. To the extent an insurer, health  
357 care center or fraternal benefit society has identified areas, systems or  
358 processes that require material improvement, updating or redesign, the  
359 insurer, health care center or fraternal benefit society shall, either  
360 directly or through an affiliate, document such identification and the  
361 remedial efforts planned and underway to address such areas, systems  
362 or processes. Such documentation must be available for inspection by  
363 the commissioner.

364 (10) Exceptions. (A) The following exceptions shall apply to this  
365 subsection:

366 (i) (I) During the period beginning on October 1, [2020] 2021, and  
367 ending on September 30, [2021] 2022, each licensee with fewer than  
368 twenty employees, which, for the purposes of this subclause, includes  
369 independent contractors having access to the nonpublic information  
370 used by such licensee or in such licensee's possession, custody or  
371 control, shall be exempt from this subsection; and

372 (II) On and after October 1, [2021] 2022, each licensee with fewer than  
373 ten employees, which, for the purposes of this subclause, includes  
374 independent contractors having access to the nonpublic information  
375 used by such licensee or in such licensee's possession, custody or  
376 control, shall be exempt from this subsection;

377 (ii) Each licensee that is subject to the Health Insurance Portability  
378 and Accountability Act of 1996, P.L. 104-191, as amended from time to  
379 time, and has established and maintains an information security

380 program pursuant to said act and the rules, regulations, procedures or  
381 guidelines established thereunder, shall be deemed to have satisfied the  
382 requirements of this subsection, provided such licensee is in compliance  
383 therewith and submits to the Insurance Commissioner, not later than  
384 April fifteenth, annually, a written statement certifying such licensee's  
385 compliance therewith;

386 (iii) Each employee, agent, representative or designee of a licensee,  
387 who is also a licensee, shall be exempt from the provisions of this  
388 subsection and need not develop its own information security program  
389 to the extent that such employee, agent representative or designee is  
390 covered by the other licensee's information security program; and

391 (iv) Each licensee that has established and maintains an information  
392 security program in compliance with [the statutes, rules and regulations  
393 of a jurisdiction approved by the commissioner pursuant to regulations  
394 adopted pursuant to subsection (i) of this section] Part 500 of Chapter I  
395 of Title 23 of the New York Codes, Rules and Regulations, as amended  
396 from time to time, shall be deemed to have satisfied the provisions of  
397 this subsection, provided such licensee is in compliance therewith and  
398 submits to the commissioner, not later than [February] April fifteenth,  
399 annually, a written statement certifying such licensee's compliance  
400 therewith.

401 (B) In the event that a licensee ceases to qualify for an exception under  
402 this subdivision, the licensee shall have one hundred eighty days to  
403 comply with this subsection.

404 (d) Investigation of a Cybersecurity Event. (1) If a licensee learns that  
405 a cybersecurity event has, or may have, occurred, the licensee, or an  
406 outside vendor or service provider, or both, designated to act on behalf  
407 of such licensee, shall conduct a prompt investigation in accordance  
408 with the provisions of this subsection.

409 (2) During any investigation conducted pursuant to subdivision (1)  
410 of this subsection, the licensee or the outside vendor or service provider,  
411 or both, shall, at a minimum and to the extent possible:

- 412 (A) Determine whether the cybersecurity event occurred; and
- 413 (B) If the cybersecurity event occurred:
- 414 (i) Assess the nature and scope of such cybersecurity event;
- 415 (ii) Identify the nonpublic information, if any, that may have been  
416 involved in such cybersecurity event; and
- 417 (iii) Perform or oversee reasonable measures to restore the security of  
418 the information systems compromised in such cybersecurity event in  
419 order to prevent further unauthorized acquisition, release or use of  
420 nonpublic information that is in the licensee's possession, custody or  
421 control.
- 422 (3) If a licensee learns that a cybersecurity event has, or may have,  
423 occurred in a system maintained by a third-party service provider, the  
424 licensee shall complete the steps listed in subdivision (2) of this  
425 subsection or confirm and document that the third-party service  
426 provider has completed such steps.
- 427 (4) Each licensee that is subject to the provisions of this subsection  
428 shall maintain records concerning each cybersecurity event for a period  
429 of at least five years from the date of such cybersecurity event, and shall  
430 produce such records to the Insurance Commissioner upon demand by  
431 the commissioner.
- 432 (e) Notification of a Cybersecurity Event. (1) Notification to the  
433 Commissioner. Each licensee shall notify the Insurance Commissioner  
434 that a cybersecurity event has occurred, as promptly as possible but in  
435 no event later than three business days after the date [of the] on which  
436 such licensee first determines that a cybersecurity event has occurred, if:
- 437 (A) Such licensee is an insurer and this state is the insurer's state of  
438 domicile, or the licensee is an insurance producer, as defined in section  
439 38a-702a, and this state is the insurance producer's home state, as  
440 defined in section 38a-702a, [;] and it is reasonably likely that the  
441 cybersecurity event will materially harm:

442 (i) A consumer residing in this state; or

443 (ii) A material part of such licensee's normal operations; or

444 (B) The licensee reasonably believes that the nonpublic information  
445 involved in the cybersecurity event is of two hundred fifty or more  
446 consumers residing in this state and:

447 (i) State or federal law requires that a notice concerning such  
448 cybersecurity event be provided to a government body, self-regulatory  
449 agency or another supervisory body; or

450 (ii) It is reasonably likely that such cybersecurity event will materially  
451 harm:

452 (I) A consumer residing in this state; or

453 (II) A material part of such licensee's normal operations.

454 (2) Information to Be Provided to Commissioner. (A) Each licensee  
455 that notifies the Insurance Commissioner pursuant to subdivision (1) of  
456 this subsection shall provide to the commissioner, in an electronic form  
457 prescribed by the commissioner, as much of the following information  
458 as possible:

459 (i) The date of the cybersecurity event;

460 (ii) A description of how the information was exposed, lost, stolen or  
461 breached, including, but not limited to, the specific roles and  
462 responsibilities of third-party service providers, if any;

463 (iii) How, and the date on which, the cybersecurity event was  
464 discovered;

465 (iv) Whether any lost, stolen or breached information has been  
466 recovered, and, if so, how such information was recovered;

467 (v) The identity of the source of the cybersecurity event;



468 (vi) Whether such licensee has filed a police report or notified any  
469 regulatory, government or law enforcement agency, and, if so, when  
470 such licensee filed such report or provided such notice;

471 (vii) A description of the specific types of exposed, lost, stolen or  
472 breached information, including, for example, specific types of medical  
473 information, financial information or information allowing  
474 identification of a consumer;

475 (viii) The period during which each information system that was  
476 compromised by the cybersecurity event was compromised by such  
477 cybersecurity event;

478 (ix) The number of total consumers residing in this state that, within  
479 such licensee's knowledge at the time that such licensee discloses such  
480 number to the commissioner, are affected by the cybersecurity event;

481 (x) The results of an internal review identifying any lapse in  
482 automated controls or internal procedures, or confirming that all such  
483 controls and procedures were followed;

484 (xi) A description of any efforts being undertaken to remediate the  
485 situation that permitted the cybersecurity event to occur;

486 (xii) A copy of the licensee's privacy policy and a statement outlining  
487 the steps the licensee will take to investigate and notify consumers  
488 affected by the cybersecurity event; and

489 (xiii) The name of a contact person who is both familiar with the  
490 cybersecurity event and authorized to act for the licensee.

491 (B) Each licensee that provides information to the Insurance  
492 Commissioner pursuant to subparagraph (A) of this subdivision shall  
493 have a continuing obligation to update and supplement such  
494 information.

495 (3) Notification to Consumers. Each licensee shall comply with all  
496 applicable provisions of section 36a-701b, and provide to the Insurance

497 Commissioner a copy of the notice that such licensee sends to  
498 consumers pursuant to said section, if any, if such licensee is required  
499 to notify the commissioner pursuant to subdivision (1) of this  
500 subsection.

501 (4) Notice Regarding Cybersecurity Events of Third-Party Service  
502 Providers. (A) In the case of a cybersecurity event involving [a] an  
503 information system maintained by a third-party service provider, each  
504 licensee affected by the event shall treat such event, if the licensee [as] is  
505 aware of such event, as such licensee would treat such event under  
506 subdivision (1) of this subsection.

507 (B) The computation of a licensee's deadlines shall begin on the day  
508 after a third-party service provider notifies the licensee of the  
509 cybersecurity event or such licensee otherwise first [becomes aware] has  
510 actual knowledge of such event, whichever is sooner.

511 (C) Nothing in this section shall prevent or abrogate an agreement  
512 between a licensee and another party to fulfill any of the investigation  
513 requirements imposed under subsection (d) of this section or the notice  
514 requirements imposed under this subsection.

515 (5) Notice Regarding Cybersecurity Events of Reinsurers to Insurers.  
516 (A) (i) In the case of a cybersecurity event involving nonpublic  
517 information that is used by a licensee that is acting as an assuming  
518 insurer or in the possession, custody or control of a licensee that is acting  
519 as an assuming insurer and that does not have a direct contractual  
520 relationship with the affected consumers, the assuming insurer shall  
521 notify its affected ceding insurers and the insurance regulatory official  
522 of its state of domicile not later than seventy-two hours after such  
523 assuming insurer discovered that the cybersecurity event had occurred.

524 (ii) Each ceding insurer that has a direct contractual relationship with  
525 the consumers affected by a cybersecurity event shall fulfill the  
526 consumer notification requirements imposed under section 36a-701b  
527 and any other notification requirements relating to a cybersecurity event  
528 imposed under this section.

529 (B) (i) In the case of a cybersecurity event involving nonpublic  
530 information that is in the possession, custody or control of a third-party  
531 service provider of a licensee, when the licensee is acting as an assuming  
532 insurer, including an assuming insurer that is domiciled in another state  
533 or jurisdiction, the assuming insurer shall notify its affected ceding  
534 insurers and the insurance regulatory official of its state of domicile not  
535 later than seventy-two hours after such assuming insurer received  
536 notice from the third-party service provider disclosing that the  
537 cybersecurity event occurred.

538 (ii) Ceding insurers that have a direct contractual relationship with  
539 affected consumers shall fulfill the consumer notification requirements  
540 imposed under section 36a-701b and any other notification  
541 requirements relating to a cybersecurity event imposed under this  
542 section.

543 (6) Notice Regarding Cybersecurity Events of Insurers to Producers  
544 of Record. If a cybersecurity event involves nonpublic information that  
545 is in the possession, custody or control of a licensee that is an insurer, or  
546 a third-party service provider for a licensee that is an insurer, and for  
547 which a consumer who is affected by the cybersecurity event accessed  
548 such licensee's services through an independent insurance producer,  
549 such licensee shall notify the producer of record for such consumer of  
550 the occurrence of such cybersecurity event in a reasonable manner and  
551 not later than the time at which notice is provided to such consumer,  
552 provided such licensee has the current producer of record information  
553 for such individual consumer.

554 (f) Power of Commissioner. (1) The Insurance Commissioner shall  
555 have power to examine and investigate into the affairs of a licensee to  
556 determine whether the licensee is, or has been, engaged in conduct in  
557 this state that violates the provisions of this section. The commissioner's  
558 power under this subsection is in addition to the commissioner's powers  
559 under sections 38a-14 to 38a-16, inclusive. Any such investigation or  
560 examination shall be conducted pursuant to said sections, if applicable.

561 (2) Whenever the Insurance Commissioner has reason to believe that  
562 a licensee is, or has been, engaged in conduct in this state that violates  
563 the provisions of this section, the commissioner shall issue and serve  
564 upon the licensee:

565 (A) A statement setting forth such violation; and

566 (B) A notice of a hearing to be held at a time and place fixed in such  
567 notice, which time shall not be less than thirty calendar days after the  
568 date of service of such notice.

569 (3) (A) The licensee shall, at the time and place fixed for the hearing  
570 in the notice issued and served upon such licensee pursuant to  
571 subdivision (2) of this subsection, have an opportunity to be heard and  
572 show cause why an order should not be entered by the Insurance  
573 Commissioner:

574 (i) Enforcing the provisions of this section; or

575 (ii) Suspending, revoking or refusing to reissue or renew any license,  
576 certificate of registration or authorization to operate the Insurance  
577 Commissioner has issued, or may issue, to such licensee.

578 (B) The Insurance Commissioner may, after holding a hearing  
579 pursuant to subparagraph (A) of this subdivision, take any action that  
580 is necessary or appropriate to enforce the provisions of this section and,  
581 in addition to or in lieu of suspending, revoking or refusing to reissue  
582 or renew any license, certificate of registration or authorization to  
583 operate the commissioner has issued, or may issue, to the licensee,  
584 impose on such licensee a civil penalty of not more than fifty thousand  
585 dollars for each violation of the provisions of this section. The  
586 commissioner may bring a civil action to recover the amount of any civil  
587 penalty that the commissioner imposes on a licensee pursuant to this  
588 subparagraph.

589 (g) Confidentiality. (1) (A) Except as provided in subparagraph (B) of  
590 this subdivision, documents, materials and other information in the

591 possession, custody or control of the Insurance Department and  
592 furnished to the department by a licensee, or an employee or agent of a  
593 licensee acting on behalf of the licensee, pursuant to subdivision (9) of  
594 subsection (c) of this section or subparagraph (A)(ii), (A)(iii), (A)(iv),  
595 (A)(v), (A)(viii), (A)(x) or (A)(xi) of subdivision (2) of subsection (e) of  
596 this section, or obtained by the commissioner in an investigation or  
597 examination conducted pursuant to subsection (f) of this section, shall  
598 be confidential by law, privileged, not subject to disclosure under  
599 section 1-210, not subject to subpoena, and not subject to discovery or  
600 admission into evidence in any private civil action.

601 (B) The Insurance Commissioner is authorized to use all documents,  
602 materials and other information in furtherance of any regulatory or legal  
603 actions brought as a part of the commissioner's duties.

604 (2) Neither the Insurance Commissioner nor any person acting under  
605 the authority of the commissioner who receives documents or materials  
606 that are, or other information that is, subject to the provisions of  
607 subdivision (1) of this subsection shall be permitted or required to testify  
608 in any private civil action concerning such documents, materials or  
609 other information.

610 (3) The Insurance Commissioner, in [order to assist the commissioner  
611 in performing] furtherance of the commissioner's duties under this  
612 section, may:

613 (A) Share documents, materials and other information, including, but  
614 not limited to, confidential and privileged documents, materials and  
615 other information subject to subdivision (1) of this subsection, with  
616 other state, federal and international regulatory agencies, the National  
617 Association of Insurance Commissioners and the affiliates and  
618 subsidiaries of said association, the Attorney General and other state,  
619 federal or international law enforcement authorities, provided the  
620 recipient of such documents, materials or other information agrees, in  
621 writing, to maintain the confidentiality and privileged status of such  
622 documents, materials or other information;

623 (B) Receive documents, materials and other information, including,  
624 but not limited to, otherwise confidential and privileged documents,  
625 materials and other information, from the National Association of  
626 Insurance Commissioners and the affiliates and subsidiaries of said  
627 association, the Attorney General and other domestic or foreign  
628 regulatory or law enforcement officials, provided the commissioner  
629 shall maintain as confidential and privileged all documents, materials  
630 and other information that the commissioner receives with notice or an  
631 understanding that such documents or materials are, or such other  
632 information is, confidential or privileged under the laws of the  
633 jurisdiction that is the source of such documents, materials or other  
634 information;

635 (C) Share documents, materials and other information subject to  
636 subdivision (1) of this subsection with a third-party consultant or  
637 vendor, provided the third-party consultant or vendor agrees, in  
638 writing, to maintain the confidentiality and privileged status of such  
639 documents, materials and other information; and

640 (D) Enter into agreements governing the sharing and use of  
641 documents, materials and other information, provided such agreements  
642 are consistent with the provisions of this subsection.

643 (4) No waiver of any applicable privilege or claim of confidentiality  
644 in a document, material or other information shall occur as a result of  
645 any disclosure of the document, material or other information to the  
646 Insurance Commissioner pursuant to this section, or as a result of any  
647 sharing of such document, material or other information authorized  
648 under subdivision (3) of this subsection.

649 (5) Nothing in this section shall prohibit the Insurance Commissioner  
650 from releasing final, adjudicated actions that are open to public  
651 inspection pursuant to section 1-210 to a database or other clearinghouse  
652 service maintained by the National Association of Insurance  
653 Commissioners or the affiliates or subsidiaries of said association.

654 (6) All documents, materials and other information provided to, and

655 in the possession, custody or control of, the National Association of  
656 Insurance Commissioners or a third-party consultant or vendor  
657 pursuant to this section shall be confidential by law, privileged, not be  
658 subject to disclosure under section 1-210, not subject to subpoena, and  
659 not subject to discovery or admission into evidence in any private civil  
660 action.

661 Sec. 4. Subsection (g) of section 38a-48 of the general statutes is  
662 repealed and the following is substituted in lieu thereof (*Effective July 1,*  
663 *2021*):

664 (g) If the actual expenditures for the fall prevention program  
665 established in section 17a-303a are less than the amount allocated, the  
666 Commissioner of Aging and Disability Services shall notify the  
667 Insurance Commissioner and the Healthcare Advocate. Immediately  
668 following the close of the fiscal year, the Insurance Commissioner and  
669 the Healthcare Advocate shall recalculate the proposed assessment for  
670 each domestic insurance company or other domestic entity in  
671 accordance with subsection (c) of this section using the actual  
672 expenditures made during the fiscal year by the Insurance Department,  
673 the Office of the Healthcare Advocate and the Office of Health Strategy  
674 from the Insurance Fund, the actual expenditures made on behalf of the  
675 department and the offices from the Capital Equipment Purchase Fund  
676 pursuant to section 4a-9, not including such expenditures made on  
677 behalf of the Health Systems Planning Unit of the Office of Health  
678 Strategy, and the actual expenditures for the fall prevention program.  
679 On or before July thirty-first, the Insurance Commissioner and the  
680 Healthcare Advocate shall render to each such domestic insurance  
681 company and other domestic entity a statement showing the difference  
682 between their respective recalculated assessments and the amount they  
683 have previously paid. On or before August thirty-first, the Insurance  
684 Commissioner and the Healthcare Advocate, after receiving any  
685 objections to such statements, shall make such adjustments which in  
686 their opinion may be indicated, and shall render an adjusted  
687 assessment, if any, to the affected companies. Any such domestic  
688 insurance company or other domestic entity may pay to the Insurance

689 Commissioner the entire assessment required under this subsection in  
690 one payment when the first installment of such assessment is due.

691 Sec. 5. Section 38a-591g of the general statutes is repealed and the  
692 following is substituted in lieu thereof (*Effective October 1, 2021*):

693 (a) (1) A covered person or a covered person's authorized  
694 representative may file a request for an external review or an expedited  
695 external review of an adverse determination or a final adverse  
696 determination in accordance with the provisions of this section. All  
697 requests for external review or expedited external review shall be made  
698 in writing to the commissioner. The commissioner may prescribe the  
699 form and content of such requests.

700 [(2) (A) All requests for external review or expedited external review  
701 shall be accompanied by a filing fee of twenty-five dollars, except that  
702 no covered person or covered person's authorized representative shall  
703 pay more than seventy-five dollars in a calendar year for such covered  
704 person. Any filing fee paid by a covered person's authorized  
705 representative shall be deemed to have been paid by the covered person.  
706 If the commissioner finds that the covered person is indigent or unable  
707 to pay the filing fee, the commissioner shall waive such fee. Any such  
708 fees shall be deposited in the Insurance Fund established under section  
709 38a-52a.

710 (B) The commissioner shall refund any paid filing fee to the covered  
711 person or the covered person's authorized representative, as applicable,  
712 or the health care professional if the adverse determination or the final  
713 adverse determination that is the subject of the external review request  
714 or expedited external review request is reversed or revised.]

715 [(3)] (2) The health carrier that issued the adverse determination or  
716 the final adverse determination that is the subject of the external review  
717 request or the expedited external review request shall pay the  
718 independent review organization for the cost of conducting the review.

719 [(4)] (3) An external review decision, whether such review is a



720 standard external review or an expedited external review, shall be  
721 binding on the health carrier or a self-insured governmental plan and  
722 the covered person, except to the extent such health carrier or covered  
723 person has other remedies available under federal or state law. A  
724 covered person or a covered person's authorized representative shall  
725 not file a subsequent request for an external review or an expedited  
726 external review that involves the same adverse determination or final  
727 adverse determination for which the covered person or the covered  
728 person's authorized representative already received an external review  
729 decision or an expedited external review decision.

730 [(5)] (4) Each health carrier shall maintain written records of external  
731 reviews as set forth in section 38a-591h.

732 [(6)] (5) Each independent review organization shall maintain written  
733 records as set forth in subsection (e) of section 38a-591m.

734 (b) (1) Except as otherwise provided under subdivision (2) of this  
735 subsection or subsection (d) of this section, a covered person or a  
736 covered person's authorized representative shall not file a request for an  
737 external review or an expedited external review until the covered  
738 person or the covered person's authorized representative has exhausted  
739 the health carrier's internal grievance process.

740 (2) A health carrier may waive its internal grievance process and the  
741 requirement for a covered person to exhaust such process prior to filing  
742 a request for an external review or an expedited external review.

743 (c) (1) At the same time a health carrier sends to a covered person or  
744 a covered person's authorized representative a written notice of an  
745 adverse determination or a final adverse determination issued by the  
746 health carrier, the health carrier shall include a written disclosure to the  
747 covered person and, if applicable, the covered person's authorized  
748 representative of the covered person's right to request an external  
749 review.

750 (2) The written notice shall include:

751 (A) The following statement or a statement in substantially similar  
752 language: "We have denied your request for benefit approval for a  
753 health care service or course of treatment. You may have the right to  
754 have our decision reviewed by health care professionals who have no  
755 association with us by submitting a request for external review to the  
756 office of the Insurance Commissioner, if our decision involved making  
757 a judgment as to the medical necessity, appropriateness, health care  
758 setting, level of care or effectiveness of the health care service or  
759 treatment you requested.";

760 (B) For a notice related to an adverse determination, a statement  
761 informing the covered person that:

762 (i) If the covered person has a medical condition for which the time  
763 period for completion of an expedited internal review of a grievance  
764 involving an adverse determination would seriously jeopardize the life  
765 or health of the covered person or would jeopardize the covered  
766 person's ability to regain maximum function, the covered person or the  
767 covered person's authorized representative may (I) file a request for an  
768 expedited external review, or (II) file a request for an expedited external  
769 review if the adverse determination involves a denial of coverage based  
770 on a determination that the recommended or requested health care  
771 service or treatment is experimental or investigational and the covered  
772 person's treating health care professional certifies in writing that such  
773 recommended or requested health care service or treatment would be  
774 significantly less effective if not promptly initiated; and

775 (ii) Such request for expedited external review may be filed at the  
776 same time the covered person or the covered person's authorized  
777 representative files a request for an expedited internal review of a  
778 grievance involving an adverse determination, except that the  
779 independent review organization assigned to conduct the expedited  
780 external review shall determine whether the covered person shall be  
781 required to complete the expedited internal review of the grievance  
782 prior to conducting the expedited external review;

783 (C) For a notice related to a final adverse determination, a statement  
784 informing the covered person that:

785 (i) If the covered person has a medical condition for which the time  
786 period for completion of an external review would seriously jeopardize  
787 the life or health of the covered person or would jeopardize the covered  
788 person's ability to regain maximum function, the covered person or the  
789 covered person's authorized representative may file a request for an  
790 expedited external review; or

791 (ii) If the final adverse determination concerns (I) an admission,  
792 availability of care, continued stay or health care service for which the  
793 covered person received emergency services but has not been  
794 discharged from a facility, the covered person or the covered person's  
795 authorized representative may file a request for an expedited external  
796 review, or (II) a denial of coverage based on a determination that the  
797 recommended or requested health care service or treatment is  
798 experimental or investigational and the covered person's treating health  
799 care professional certifies in writing that such recommended or  
800 requested health care service or treatment would be significantly less  
801 effective if not promptly initiated, the covered person or the covered  
802 person's authorized representative may file a request for an expedited  
803 external review;

804 (D) (i) A copy of the description of both the standard and expedited  
805 external review procedures the health carrier is required to provide,  
806 highlighting the provisions in the external review procedures that give  
807 the covered person or the covered person's authorized representative  
808 the opportunity to submit additional information and including any  
809 forms used to process an external review or an expedited external  
810 review;

811 (ii) As part of any forms provided under subparagraph (D)(i) of this  
812 subdivision, an authorization form or other document approved by the  
813 commissioner that complies with the requirements of 45 CFR 164.508,  
814 as amended from time to time, by which the covered person shall

815 authorize the health carrier and the covered person's treating health care  
816 professional to release, transfer or otherwise divulge, in accordance with  
817 sections 38a-975 to 38a-999a, inclusive, the covered person's protected  
818 health information including medical records for purposes of  
819 conducting an external review or an expedited external review;

820 (E) A statement that the covered person or the covered person's  
821 authorized representative may request, free of charge, copies of all  
822 documents, communications, information and evidence regarding the  
823 adverse determination or the final adverse determination that were not  
824 previously provided to the covered person or the covered person's  
825 authorized representative.

826 (3) Upon request pursuant to subparagraph (E) of subdivision (2) of  
827 this subsection, the health carrier shall provide such copies in  
828 accordance with subsection (b) of section 38a-591n.

829 (d) (1) A covered person or a covered person's authorized  
830 representative may file a request for an expedited external review of an  
831 adverse determination or a final adverse determination with the  
832 commissioner, except that an expedited external review shall not be  
833 provided for a retrospective review request of an adverse determination  
834 or a final adverse determination.

835 (2) Such request may be filed at the time the covered person receives:

836 (A) An adverse determination, if:

837 (i) (I) The covered person has a medical condition for which the time  
838 period for completion of an expedited internal review of the adverse  
839 determination would seriously jeopardize the life or health of the  
840 covered person or would jeopardize the covered person's ability to  
841 regain maximum function; or

842 (II) The denial of coverage is based on a determination that the  
843 recommended or requested health care service or treatment is  
844 experimental or investigational and the covered person's treating health

845 care professional certifies in writing that such recommended or  
846 requested health care service or treatment would be significantly less  
847 effective if not promptly initiated; and

848 (ii) The covered person or the covered person's authorized  
849 representative has filed a request for an expedited internal review of the  
850 adverse determination; or

851 (B) A final adverse determination if:

852 (i) The covered person has a medical condition where the time period  
853 for completion of a standard external review would seriously jeopardize  
854 the life or health of the covered person or would jeopardize the covered  
855 person's ability to regain maximum function;

856 (ii) The final adverse determination concerns an admission,  
857 availability of care, continued stay or health care service for which the  
858 covered person received emergency services but has not been  
859 discharged from a facility; or

860 (iii) The denial of coverage is based on a determination that the  
861 recommended or requested health care service or treatment is  
862 experimental or investigational and the covered person's treating health  
863 care professional certifies in writing that such recommended or  
864 requested health care service or treatment would be significantly less  
865 effective if not promptly initiated.

866 (3) Such covered person or covered person's authorized  
867 representative shall not be required to file a request for an external  
868 review prior to, or at the same time as, the filing of a request for an  
869 expedited external review and shall not be precluded from filing a  
870 request for an external review, within the time periods set forth in  
871 subsection (e) of this section, if the request for an expedited external  
872 review is determined to be ineligible for such review.

873 (e) (1) Not later than one hundred twenty calendar days after a  
874 covered person or a covered person's authorized representative receives

875 a notice of an adverse determination or a final adverse determination,  
876 the covered person or the covered person's authorized representative  
877 may file a request for an external review or an expedited external review  
878 with the commissioner in accordance with this section.

879 (2) (A) Not later than one business day after the commissioner  
880 receives a request that is complete, the commissioner shall: [send]

881 (i) Send a copy of such request to the health carrier that issued the  
882 adverse determination or the final adverse determination that is the  
883 subject of the request; [.] and

884 (ii) Assign an independent review organization from the list of  
885 approved independent review organizations compiled and maintained  
886 by the commissioner pursuant to section 38a-591l to conduct the review  
887 and notify the health carrier of the name of the assigned independent  
888 review organization. Such assignment shall be done on a random basis  
889 among those approved independent review organizations qualified to  
890 conduct the particular review based on the nature of the health care  
891 service that is the subject of the adverse determination or the final  
892 adverse determination and other circumstances, including conflict of  
893 interest concerns as set forth in section 38a-591m.

894 (3) Not later than five business days after the health carrier receives  
895 the copy of an external review request or one calendar day after the  
896 health carrier receives the copy of an expedited external review request,  
897 from the commissioner, the health carrier shall complete a preliminary  
898 review of the request to determine whether:

899 (A) The individual is or was a covered person under the health  
900 benefit plan at the time the health care service was requested or, in the  
901 case of an external review of a retrospective review request, was a  
902 covered person in the health benefit plan at the time the health care  
903 service was provided;

904 (B) The health care service that is the subject of the adverse  
905 determination or the final adverse determination is a covered service

906 under the covered person's health benefit plan but for the health  
907 carrier's determination that the health care service is not covered  
908 because [it] the health care service does not meet the health carrier's  
909 requirements for medical necessity, appropriateness, health care setting,  
910 level of care or effectiveness;

911 (C) If the health care service or treatment is experimental or  
912 investigational:

913 (i) Is a covered benefit under the covered person's health benefit plan  
914 but for the health carrier's determination that the service or treatment is  
915 experimental or investigational for a particular medical condition;

916 (ii) Is not explicitly listed as an excluded benefit under the covered  
917 person's health benefit plan;

918 (iii) The covered person's treating health care professional has  
919 certified that one of the following situations is applicable:

920 (I) Standard health care services or treatments have not been effective  
921 in improving the medical condition of the covered person;

922 (II) Standard health care services or treatments are not medically  
923 appropriate for the covered person; or

924 (III) There is no available standard health care service or treatment  
925 covered by the health carrier that is more beneficial than the  
926 recommended or requested health care service or treatment; and

927 (iv) The covered person's treating health care professional:

928 (I) Has recommended a health care service or treatment that the  
929 health care professional certifies, in writing, is likely to be more  
930 beneficial to the covered person, in the health care professional's  
931 opinion, than any available standard health care services or treatments;  
932 or

933 (II) Is a licensed, board certified or board eligible health care

934 professional qualified to practice in the area of medicine appropriate to  
935 treat the covered person's condition and has certified in writing that  
936 scientifically valid studies using accepted protocols demonstrate that  
937 the health care service or treatment requested by the covered person that  
938 is the subject of the adverse determination or the final adverse  
939 determination is likely to be more beneficial to the covered person than  
940 any available standard health care services or treatments;

941 (D) The covered person has exhausted the health carrier's internal  
942 grievance process or the covered person or the covered person's  
943 authorized representative has filed a request for an expedited external  
944 review as provided under subsection (d) of this section; and

945 (E) The covered person has provided all the information and forms  
946 required to process an external review or an expedited external review,  
947 including an authorization form as set forth in subparagraph (D)(ii) of  
948 subdivision (2) of subsection (c) of this section.

949 (4) (A) Not later than one business day after the preliminary review  
950 of an external review request or the day the preliminary review of an  
951 expedited external review request is completed, the health carrier shall  
952 notify the commissioner, the covered person and, if applicable, the  
953 covered person's authorized representative in writing whether the  
954 request for an external review or an expedited external review is  
955 complete and eligible for such review. The commissioner may specify  
956 the form for the health carrier's notice of initial determination under this  
957 subdivision and any supporting information required to be included in  
958 the notice.

959 (B) If the external review or the expedited external review is accepted,  
960 the health carrier shall notify the commissioner, the covered person and,  
961 if applicable, the covered person's authorized representative in writing  
962 of the request's eligibility and acceptance for external review or  
963 expedited external review. For an external review, the health carrier  
964 shall include in such notice (i) a statement that the covered person or the  
965 covered person's authorized representative may submit, not later than



966 five business days after the covered person or the covered person's  
967 authorized representative, as applicable, received such notice,  
968 additional information in writing to the assigned independent review  
969 organization that such organization shall consider when conducting the  
970 external review, and (ii) where and how such additional information is  
971 to be submitted. If additional information is submitted later than five  
972 business days after the covered person or the covered person's  
973 authorized representative, as applicable, received such notice, the  
974 independent review organization may, but shall not be required to,  
975 accept and consider such additional information.

976 [(B)] (C) If the request:

977 (i) Is not complete, the health carrier shall notify the commissioner  
978 and the covered person and, if applicable, the covered person's  
979 authorized representative in writing and include in the notice what  
980 information or materials are needed to perfect the request; or

981 (ii) Is not eligible for external review or expedited external review,  
982 the health carrier shall notify the commissioner, the covered person and,  
983 if applicable, the covered person's authorized representative in writing  
984 and include in the notice the reasons for its ineligibility.

985 [(C)] (D) The notice of initial determination shall include a statement  
986 informing the covered person and, if applicable, the covered person's  
987 authorized representative that a health carrier's initial determination  
988 that the request for an external review or an expedited external review  
989 is ineligible for review may be appealed to the commissioner.

990 [(D)] (E) Notwithstanding a health carrier's initial determination that  
991 a request for an external review or an expedited external review is  
992 ineligible for review, the commissioner may determine, pursuant to the  
993 terms of the covered person's health benefit plan, that such request is  
994 eligible for such review and assign an independent review organization  
995 to conduct such review. Any such review shall be conducted in  
996 accordance with this section.

997 [(f) (1) Whenever the commissioner is notified pursuant to  
998 subparagraph (A) of subdivision (4) of subsection (e) of this section that  
999 a request is eligible for external review or expedited external review, the  
1000 commissioner shall, not later than one business day after receiving such  
1001 notice for an external review or one calendar day after receiving such  
1002 notice for an expedited external review:

1003 (A) Assign an independent review organization from the list of  
1004 approved independent review organizations compiled and maintained  
1005 by the commissioner pursuant to section 38a-591l to conduct the review  
1006 and notify the health carrier of the name of the assigned independent  
1007 review organization. Such assignment shall be done on a random basis  
1008 among those approved independent review organizations qualified to  
1009 conduct the particular review based on the nature of the health care  
1010 service that is the subject of the adverse determination or the final  
1011 adverse determination and other circumstances, including conflict of  
1012 interest concerns as set forth in section 38a-591m; and

1013 (B) Notify the covered person and, if applicable, the covered person's  
1014 authorized representative in writing of the request's eligibility and  
1015 acceptance for external review or expedited external review. For an  
1016 external review, the commissioner shall include in such notice (i) a  
1017 statement that the covered person or the covered person's authorized  
1018 representative may submit, not later than five business days after the  
1019 covered person or the covered person's authorized representative, as  
1020 applicable, received such notice, additional information in writing to the  
1021 assigned independent review organization that such organization shall  
1022 consider when conducting the external review, and (ii) where and how  
1023 such additional information is to be submitted. If additional information  
1024 is submitted later than five business days after the covered person or the  
1025 covered person's authorized representative, as applicable, received such  
1026 notice, the independent review organization may, but shall not be  
1027 required to, accept and consider such additional information.]

1028 [(2)] (f) (1) Not later than five business days for an external review or  
1029 one calendar day for an expedited external review, after the health

1030 carrier [receives notice of the name of the assigned independent review  
1031 organization from the commissioner] accepts the external review or  
1032 expedited external review, the health carrier or its designee utilization  
1033 review company shall provide to the assigned independent review  
1034 organization the documents and any information such health carrier or  
1035 utilization review company considered in making the adverse  
1036 determination or the final adverse determination.

1037 [(3)] (2) The failure of the health carrier or its designee utilization  
1038 review company to provide the documents and information within the  
1039 time specified in subdivision [(2)] (1) of this subsection shall not delay  
1040 the conducting of the review.

1041 [(4)] (3) (A) If the health carrier or its designee utilization review  
1042 company fails to provide the documents and information within the  
1043 time period specified in subdivision [(2)] (1) of this subsection, the  
1044 independent review organization may terminate the review and make  
1045 a decision to reverse the adverse determination or the final adverse  
1046 determination.

1047 (B) Not later than one business day after terminating the review and  
1048 making the decision to reverse the adverse determination or the final  
1049 adverse determination, the independent review organization shall  
1050 notify the commissioner, the health carrier, the covered person and, if  
1051 applicable, the covered person's authorized representative in writing of  
1052 such decision.

1053 (g) (1) The assigned independent review organization shall review all  
1054 the information and documents received pursuant to subsection (f) of  
1055 this section. In reaching a decision, the independent review organization  
1056 shall not be bound by any decisions or conclusions reached during the  
1057 health carrier's utilization review process.

1058 (2) Not later than one business day after receiving any information  
1059 submitted by the covered person or the covered person's authorized  
1060 representative pursuant to subparagraph (B) of subdivision [(1)] (4) of  
1061 subsection [(f)] (e) of this section, the independent review organization

1062 shall forward such information to the health carrier.

1063 (3) (A) Upon the receipt of any information forwarded pursuant to  
1064 subdivision (2) of this subsection, the health carrier may reconsider its  
1065 adverse determination or the final adverse determination that is the  
1066 subject of the review. Such reconsideration shall not delay or terminate  
1067 the review.

1068 (B) The independent review organization shall terminate the review  
1069 if the health carrier decides, upon completion of its reconsideration and  
1070 notice to such organization as provided in subparagraph (C) of this  
1071 subdivision, to reverse its adverse determination or its final adverse  
1072 determination and provide coverage or payment for the health care  
1073 service or treatment that is the subject of the adverse determination or  
1074 the final adverse determination.

1075 (C) Not later than one business day after making the decision to  
1076 reverse its adverse determination or its final adverse determination, the  
1077 health carrier shall notify the commissioner, the assigned independent  
1078 review organization, the covered person and, if applicable, the covered  
1079 person's authorized representative in writing of such decision.

1080 (h) In addition to the documents and information received pursuant  
1081 to subsection (f) of this section, the independent review organization  
1082 shall consider, to the extent the documents or information are available  
1083 and the independent review organization considers them appropriate,  
1084 the following in reaching a decision:

1085 (1) The covered person's medical records;

1086 (2) The attending health care professional's recommendation;

1087 (3) Consulting reports from appropriate health care professionals and  
1088 other documents submitted by the health carrier, the covered person,  
1089 the covered person's authorized representative or the covered person's  
1090 treating health care professional;

1091 (4) The terms of coverage under the covered person's health benefit

1092 plan to ensure that the independent review organization's decision is  
1093 not contrary to the terms of coverage under such health benefit plan;

1094 (5) The most appropriate practice guidelines, which shall include  
1095 applicable evidence-based standards and may include any other  
1096 practice guidelines developed by the federal government, national or  
1097 professional medical societies, medical boards or medical associations;

1098 (6) Any applicable clinical review criteria developed and used by the  
1099 health carrier or its designee utilization review company; and

1100 (7) The opinion or opinions of the independent review organization's  
1101 clinical peer or peers who conducted the review after considering  
1102 subdivisions (1) to (6), inclusive, of this subsection.

1103 (i) (1) The independent review organization shall notify the  
1104 commissioner, the health carrier, the covered person and, if applicable,  
1105 the covered person's authorized representative in writing of its decision  
1106 to uphold, reverse or revise the adverse determination or the final  
1107 adverse determination, not later than:

1108 (A) For external reviews, forty-five calendar days after such  
1109 organization receives the assignment from the commissioner to conduct  
1110 such review;

1111 (B) For external reviews involving a determination that the  
1112 recommended or requested health care service or treatment is  
1113 experimental or investigational, twenty calendar days after such  
1114 organization receives the assignment from the commissioner to conduct  
1115 such review;

1116 (C) For expedited external reviews, except as specified under  
1117 subparagraph (D) of this subdivision, as expeditiously as the covered  
1118 person's medical condition requires, but not later than forty-eight hours  
1119 after such organization receives the assignment from the commissioner  
1120 to conduct such review or seventy-two hours after such organization  
1121 receives such assignment if any portion of such forty-eight-hour period

1122 falls on a weekend;

1123 (D) For expedited external reviews involving a health care service or  
1124 course of treatment specified under subparagraph (B) or (C) of  
1125 subdivision (38) of section 38a-591a, as expeditiously as the covered  
1126 person's medical condition requires, but not later than twenty-four  
1127 hours after such organization receives the assignment from the  
1128 commissioner to conduct such review; and

1129 (E) For expedited external reviews involving a determination that the  
1130 recommended or requested health care service or treatment is  
1131 experimental or investigational, as expeditiously as the covered person's  
1132 medical condition requires, but not later than five calendar days after  
1133 such organization receives the assignment from the commissioner to  
1134 conduct such review.

1135 (2) Such notice shall include:

1136 (A) A general description of the reason for the request for the review;

1137 (B) The date the independent review organization received the  
1138 assignment from the commissioner to conduct the review;

1139 (C) The date the review was conducted;

1140 (D) The date the organization made its decision;

1141 (E) The principal reason or reasons for its decision, including what  
1142 applicable evidence-based standards, if any, were used as a basis for its  
1143 decision;

1144 (F) The rationale for the organization's decision;

1145 (G) Reference to the evidence or documentation, including any  
1146 evidence-based standards, considered by the organization in reaching  
1147 its decision; and

1148 (H) For a review involving a determination that the recommended or

1149 requested health care service or treatment is experimental or  
1150 investigational:

1151 (i) A description of the covered person's medical condition;

1152 (ii) A description of the indicators relevant to determining whether  
1153 there is sufficient evidence to demonstrate that (I) the recommended or  
1154 requested health care service or treatment is likely to be more beneficial  
1155 to the covered person than any available standard health care services  
1156 or treatments, and (II) the adverse risks of the recommended or  
1157 requested health care service or treatment would not be substantially  
1158 increased over those of available standard health care services or  
1159 treatments;

1160 (iii) A description and analysis of any medical or scientific evidence  
1161 considered in reaching the opinion;

1162 (iv) A description and analysis of any evidence-based standard; and

1163 (v) Information on whether the clinical peer's rationale for the  
1164 opinion is based on the documents and information set forth in  
1165 subsection (f) of this section.

1166 (3) Upon the receipt of a notice of the independent review  
1167 organization's decision to reverse or revise an adverse determination or  
1168 a final adverse determination, the health carrier shall immediately  
1169 approve the coverage that was the subject of the adverse determination  
1170 or the final adverse determination.

1171 Sec. 6. Section 38a-85 of the general statutes is repealed and the  
1172 following is substituted in lieu thereof (*Effective October 1, 2021*):

1173 (a) (1) Credit for reinsurance shall be allowed a domestic ceding  
1174 insurer as either an asset or a deduction from liability on account of  
1175 reinsurance ceded only when the reinsurer meets the requirements of:

1176 [(1)] (A) Subsection (b) of this section;

- 1177        [(2)] (B) Subsection (c) of this section;
- 1178        [(3)] (C) Subsections (d) and (h) of this section;
- 1179        [(4)] (D) Subsections (e), (h) and (i) of this section;
- 1180        [(5)] (E) Subsections (f) and (i) of this section;
- 1181        [(6)] (F) Subsection (g) of this section; [or]
- 1182        (G) Subsection (h) of this section; or
- 1183        [(7)] (H) Any regulation adopted pursuant to subsection (b) of section
- 1184        38a-88, as amended by this act.

1185        (2) Credit shall be allowed under subsection (b), (c) or (d) of this

1186        section only as respects cessions of those kinds or classes of business

1187        which the assuming insurer is licensed or otherwise permitted to write

1188        or assume in its state of domicile, or, in the case of a United States branch

1189        of an alien assuming insurer, in the state through which it is entered and

1190        licensed to transact insurance or reinsurance. Credit shall be allowed

1191        under subsection (d) or (e) of this section only if the applicable

1192        requirements of subsection (i) of this section have been satisfied.

1193        (b) Credit shall be allowed when the reinsurance is ceded to an

1194        assuming insurer that is licensed to transact insurance or reinsurance in

1195        this state.

1196        (c) (1) Credit shall be allowed when the reinsurance is ceded to an

1197        assuming insurer that is accredited by the commissioner as a reinsurer

1198        in this state. To be eligible for accreditation, an insurer shall (A) file with

1199        the commissioner evidence of its submission to this state's jurisdiction,

1200        (B) submit to this state's authority to examine its books and records, (C)

1201        be licensed to transact insurance or reinsurance in at least one state, or

1202        in the case of a United States branch of an alien assuming insurer is

1203        entered through and licensed to transact insurance or reinsurance in at

1204        least one state, (D) file annually with the commissioner a copy of its

1205        annual statement filed with the insurance department of its state of



1206 domicile and a copy of its most recent audited financial statement, and  
1207 (E) demonstrate to the satisfaction of the commissioner that it has  
1208 adequate financial capacity to meet its reinsurance obligations and is  
1209 otherwise qualified to assume reinsurance from a domestic insurer. An  
1210 assuming insurer shall be deemed to meet the requirements of this  
1211 subparagraph if it maintains a surplus with regard to policyholders of  
1212 not less than twenty million dollars at the time of accreditation and its  
1213 accreditation has not been denied by the commissioner within ninety  
1214 days after the date the insurer submitted its application.

1215 (2) Each accredited reinsurer doing business in this state shall,  
1216 annually, on or before the first day of March, submit to the  
1217 commissioner, by electronically filing with the National Association of  
1218 Insurance Commissioners, a true and complete report, signed and  
1219 sworn to by its president or a vice president, and secretary or an  
1220 assistant secretary, of its financial condition on the thirty-first day of  
1221 December next preceding, prepared in accordance with the National  
1222 Association of Insurance Commissioners annual statement instructions  
1223 handbook and following those accounting procedures and practices  
1224 prescribed by the National Association of Insurance Commissioners  
1225 accounting practices and procedures manual, subject to any deviations  
1226 in form and detail as may be prescribed by the commissioner. An  
1227 electronically filed report in accordance with section 38a-53a that is  
1228 timely submitted to the National Association of Insurance  
1229 Commissioners shall be deemed to have been submitted to the  
1230 commissioner in accordance with this subdivision.

1231 (d) Credit shall be allowed when the reinsurance is ceded to an  
1232 assuming insurer that is domiciled and licensed in, or in the case of a  
1233 United States branch of an alien assuming insurer is entered through, a  
1234 state that employs standards regarding credit for reinsurance  
1235 substantially similar to those applicable in this state and the assuming  
1236 insurer or United States branch of an alien assuming insurer (1)  
1237 maintains a surplus with regard to policyholders in an amount not less  
1238 than twenty million dollars, and (2) submits to the authority of this state  
1239 to examine its books and records. The requirement of subdivision (1) of

1240 this subsection shall not apply to reinsurance ceded and assumed  
1241 pursuant to pooling arrangements among insurers in the same holding  
1242 company system.

1243 (e) (1) Credit shall be allowed when the reinsurance is ceded to an  
1244 assuming insurer that maintains a trust that complies with the  
1245 requirements of subdivisions (2) and (3) of this subsection in a qualified  
1246 United States financial institution, as defined in section 38a-87, for the  
1247 payment of the valid claims of its United States policyholders and  
1248 ceding insurers, and their assigns and successors in interest. The  
1249 assuming insurer shall (A) report annually to the commissioner  
1250 information substantially the same as that required to be reported in the  
1251 National Association of Insurance Commissioners' Annual Statement  
1252 form by licensed insurers, to enable the commissioner to determine the  
1253 sufficiency of the trust fund, and (B) submit to, and pay the expenses of,  
1254 examination of its books and records by the commissioner.

1255 (2) (A) No credit for reinsurance shall be allowed under subdivision  
1256 (1) of this subsection unless:

1257 (i) The form of the trust and any amendments to the trust have been  
1258 approved by (I) the insurance regulatory official of the state of domicile  
1259 of the trust, or (II) the insurance regulatory official of another state who  
1260 has, pursuant to the terms of the trust instrument, accepted principal  
1261 regulatory oversight of the trust;

1262 (ii) The form of the trust and any amendments to the trust have been  
1263 filed with the insurance regulatory officials of each state in which ceding  
1264 insurer beneficiaries of the trust are domiciled; and

1265 (iii) The trust instrument (I) provides that a contested claim shall be  
1266 valid and enforceable upon the entry of a final order of a court of  
1267 competent jurisdiction in the United States, and (II) vests legal title to its  
1268 assets in its trustees for the benefit of the assuming insurer's domestic  
1269 and foreign policyholders and ceding insurers, and their assigns and  
1270 successors in interest.

1271 (B) (i) The trust shall be subject to examination by the commissioner  
1272 and shall remain in effect for as long as the assuming insurer has  
1273 outstanding obligations due under the reinsurance agreements subject  
1274 to the trust.

1275 (ii) Not later than March first, annually, the trustee of the trust shall  
1276 (I) report to the commissioner, in writing, the balance and a list of the  
1277 investments of the trust at the end of the preceding calendar year, and  
1278 (II) certify to the commissioner the date of termination of the trust, if so  
1279 planned, or that the trust will not expire prior to the following December  
1280 thirty-first.

1281 (3) (A) (i) In the case of a single assuming insurer, the trust shall  
1282 consist of a trusteed account with funds in an amount not less than the  
1283 assuming insurer's liabilities attributable to reinsurance ceded by  
1284 domestic and foreign ceding insurers and, unless otherwise provided in  
1285 subparagraph (A)(ii) of this subdivision, the assuming insurer shall  
1286 maintain a trusteed surplus of not less than twenty million dollars.

1287 (ii) (I) The insurance regulatory official with principal oversight of the  
1288 trust may authorize a reduction in the required trusteed surplus.

1289 (II) For a trust over which the commissioner has principal regulatory  
1290 oversight, at any time after the assuming insurer has permanently  
1291 discontinued for at least three full years underwriting new business  
1292 secured by the trust, the commissioner may authorize a reduction in the  
1293 required trusteed surplus. Such reduction shall be made only after the  
1294 commissioner finds, based on a risk assessment, that the reduced  
1295 surplus level is adequate to protect domestic and foreign policyholders  
1296 and ceding insurers and claimants in light of reasonably foreseeable  
1297 adverse loss development. The risk assessment may involve an actuarial  
1298 review, including an independent analysis of reserves and cash flows,  
1299 and shall consider all material risk factors, including, when applicable,  
1300 the lines of business involved, the stability of the incurred loss estimates  
1301 and the effect of the surplus requirements on the assuming insurer's  
1302 liquidity or solvency. The minimum required surplus shall not be

1303 reduced to an amount less than thirty per cent of the assuming insurer's  
1304 liabilities attributable to reinsurance ceded by domestic and foreign  
1305 ceding insurers covered by the trust.

1306 (B) In the case of an assuming insurer that is a group including  
1307 incorporated and individual unincorporated underwriters:

1308 (i) (I) For reinsurance ceded under a reinsurance agreement with an  
1309 inception date prior to January 1, 1993, and not amended or renewed  
1310 after said date, the trust shall consist of a trusteed account with funds in  
1311 an amount not less than such underwriters' several insurance and  
1312 reinsurance liabilities attributable to business written in the United  
1313 States; or

1314 (II) For reinsurance ceded under a reinsurance agreement with an  
1315 inception date on or after January 1, 1993, the trust shall consist of a  
1316 trusteed account with funds in an amount not less than such  
1317 underwriters' several liabilities attributable to business ceded by  
1318 domestic and foreign ceding insurers to any underwriter who is a  
1319 member of the group; [and]

1320 (ii) In addition to a trust specified in subparagraph (B)(i)(I) or (B)(i)(II)  
1321 of this subdivision, the group shall maintain, for all years of account, a  
1322 trusteed surplus of which one hundred million dollars shall be held  
1323 jointly for the benefit of domestic and foreign ceding insurers of any  
1324 member of the group; [and]

1325 (iii) The incorporated members of the group shall not be engaged in  
1326 any business other than underwriting as a member of the group and  
1327 shall be subject to the same level of solvency regulation and solvency  
1328 control by the group's domiciliary insurance regulatory official as are  
1329 the unincorporated members; and

1330 (iv) Not later than ninety days after its financial statements are due to  
1331 be filed with the group's domiciliary insurance regulatory official, the  
1332 group shall provide to the commissioner an annual certification by the  
1333 group's domiciliary insurance regulatory official of the solvency of each

1334 underwriter who is a member of the group or, if such certification is not  
1335 provided by the group's domiciliary insurance regulatory official,  
1336 financial statements prepared by independent public accountants of  
1337 each such underwriter.

1338 (C) In the case of a group of incorporated underwriters under  
1339 common administration:

1340 (i) The group shall be accredited and have continuously transacted  
1341 an insurance business outside the United States for at least three years  
1342 immediately prior to applying for accreditation;

1343 (ii) The trust shall consist of a trusteed account with funds in an  
1344 amount not less than such underwriters' several liabilities attributable  
1345 to business ceded by domestic and foreign ceding insurers pursuant to  
1346 a reinsurance contract issued in the name of the group to any  
1347 underwriter who is a member of the group;

1348 (iii) In addition to such trust, the group shall maintain (I) an aggregate  
1349 policyholders' surplus of not less than ten billion dollars, and (II) a joint  
1350 trusteed surplus of which one hundred million dollars shall be held  
1351 jointly for the benefit of domestic and foreign ceding insurers of any  
1352 member of the group as additional security for these liabilities; and

1353 (iv) Not later than ninety days after its financial statements are due to  
1354 be filed with the group's domiciliary insurance regulatory official, the  
1355 group shall make available to the commissioner an annual certification  
1356 by the group's domiciliary insurance regulatory official of the solvency  
1357 of each underwriter who is a member of the group and financial  
1358 statements prepared by independent public accountants of each such  
1359 underwriter.

1360 (f) (1) Credit shall be allowed when the reinsurance is ceded to an  
1361 assuming insurer that is certified in accordance with section 38a-85a by  
1362 the commissioner as a reinsurer in this state and such certified reinsurer  
1363 maintains security in a form and amounts set forth in subdivision (3) of  
1364 subsection (e) of this section or, for a multibeneficiary trust set forth in

1365 subdivision (2) of subsection (e) of section 38a-85a, in accordance with  
1366 the provisions of subdivision (2) of subsection (e) of section 38a-85a.

1367 (2) If the security is not sufficient with respect to obligations incurred  
1368 by a certified reinsurer, the commissioner shall reduce the credit  
1369 allowed by an amount proportionate to the deficiency and may impose  
1370 further reductions in the credit allowed if the commissioner finds there  
1371 is a material risk that such obligations will not be paid in full when due.

1372 (g) (1) Credit shall be allowed when the reinsurance is ceded to an  
1373 assuming insurer meeting each of the conditions set forth below:

1374 (A) The assuming insurer shall have its head office or be domiciled  
1375 in, as applicable, and be licensed in a reciprocal jurisdiction. A  
1376 "reciprocal jurisdiction" is a jurisdiction that meets one of the following:

1377 (i) A non-United States jurisdiction that is subject to an in-force  
1378 covered agreement with the United States, each within its legal  
1379 authority, or, in the case of a covered agreement between the United  
1380 States and the European Union, is a member state of the European  
1381 Union. For purposes of this subsection, a "covered agreement" is an  
1382 agreement entered into pursuant to the Dodd-Frank Wall Street Reform  
1383 and Consumer Protection Act, 31 USC Sections 313 and 314, that is  
1384 currently in effect or in a period of provisional application and  
1385 addresses the elimination, under specified conditions, of collateral  
1386 requirements as a condition for entering into any reinsurance agreement  
1387 with a ceding insurer domiciled in this state or for allowing the ceding  
1388 insurer to recognize credit for reinsurance;

1389 (ii) A United States jurisdiction that meets the requirements for  
1390 accreditation under the National Association of Insurance  
1391 Commissioners' financial standards and accreditation program; or

1392 (iii) A qualified jurisdiction, as determined by the commissioner  
1393 pursuant to subsection (c) of section 38a-85a, which is not otherwise  
1394 described in subparagraph (A)(i) or (A)(ii) of this subdivision and which  
1395 meets certain additional requirements, consistent with the terms and

1396 conditions of in-force covered agreements, as specified by the  
1397 commissioner in regulations adopted in accordance with the provisions  
1398 of chapter 54.

1399 (B) The assuming insurer shall have and maintain, on an ongoing  
1400 basis, minimum capital and surplus, or its equivalent, calculated  
1401 according to the methodology of its domiciliary jurisdiction, in an  
1402 amount to be set forth in regulation. If the assuming insurer is an  
1403 association, including incorporated and individual unincorporated  
1404 underwriters, it shall have and maintain, on an ongoing basis, minimum  
1405 capital and surplus equivalents, net of liabilities, calculated according to  
1406 the methodology applicable in its domiciliary jurisdiction, and a central  
1407 fund containing a balance in amounts to be set forth in regulation.

1408 (C) The assuming insurer shall have and maintain, on an ongoing  
1409 basis, a minimum solvency or capital ratio, as applicable, which will be  
1410 set forth in regulation. If the assuming insurer is an association,  
1411 including incorporated and individual unincorporated underwriters, it  
1412 shall have and maintain, on an ongoing basis, a minimum solvency or  
1413 capital ratio in the reciprocal jurisdiction where the assuming insurer  
1414 has its head office or is domiciled, as applicable, and is also licensed.

1415 (D) The assuming insurer shall agree and provide adequate  
1416 assurance to the commissioner, in a form specified by the commissioner  
1417 pursuant to regulation, as follows:

1418 (i) The assuming insurer shall provide prompt written notice and  
1419 explanation to the commissioner if it falls below the minimum  
1420 requirements set forth in subparagraph (B) or (C) of this subdivision, or  
1421 if any regulatory action is taken against it for serious noncompliance  
1422 with applicable law;

1423 (ii) The assuming insurer shall consent in writing to the jurisdiction  
1424 of the courts of this state and to the appointment of the commissioner as  
1425 agent for service of process. The commissioner may require that consent  
1426 for service of process be provided to the commissioner and included in  
1427 each reinsurance agreement. Nothing in this provision shall limit, or in

1428 any way alter, the capacity of parties to a reinsurance agreement to agree  
1429 to alternative dispute resolution mechanisms, except to the extent such  
1430 agreements are unenforceable under applicable insolvency or  
1431 delinquency laws;

1432 (iii) The assuming insurer shall consent in writing to pay all final  
1433 judgments, wherever enforcement is sought, obtained by a ceding  
1434 insurer or its legal successor, that have been declared enforceable in the  
1435 jurisdiction where the judgment was obtained;

1436 (iv) Each reinsurance agreement shall include a provision requiring  
1437 the assuming insurer to provide security in an amount equal to one  
1438 hundred per cent of the assuming insurer's liabilities attributable to  
1439 reinsurance ceded pursuant to that agreement if the assuming insurer  
1440 resists enforcement of a final judgment that is enforceable under the law  
1441 of the jurisdiction in which it was obtained or a properly enforceable  
1442 arbitration award, whether obtained by the ceding insurer or by its legal  
1443 successor on behalf of its resolution estate; and

1444 (v) The assuming insurer shall confirm that it is not presently  
1445 participating in any solvent scheme of arrangement that involves this  
1446 state's ceding insurers, and agree to notify the ceding insurer and the  
1447 commissioner and to provide security in an amount equal to one  
1448 hundred per cent of the assuming insurer's liabilities to the ceding  
1449 insurer, should the assuming insurer enter into such a solvent scheme  
1450 of arrangement. Such security shall be in a form consistent with the  
1451 provisions of subsection (f) of this section and sections 38a-85a and 38a-  
1452 86 and as specified in regulations adopted by the commissioner in  
1453 accordance with the provisions of chapter 54.

1454 (E) The assuming insurer or its legal successor shall provide, if  
1455 requested by the commissioner, on behalf of itself and any legal  
1456 predecessors, certain documentation to the commissioner, as specified  
1457 by the commissioner in regulation.

1458 (F) The assuming insurer shall maintain a practice of prompt  
1459 payment of claims under reinsurance agreements, pursuant to criteria



1460 set forth in regulation.

1461 (G) The assuming insurer's supervisory authority shall confirm to the  
1462 commissioner on an annual basis, as of the preceding December thirty-  
1463 first or at the annual date otherwise statutorily reported to the reciprocal  
1464 jurisdiction, that the assuming insurer complies with the requirements  
1465 set forth in subparagraphs (B) and (C) of this subdivision.

1466 (H) Nothing in this provision precludes an assuming insurer from  
1467 providing the commissioner with information on a voluntary basis.

1468 (2) The commissioner shall timely create and publish a list of  
1469 reciprocal jurisdictions.

1470 (A) A list of reciprocal jurisdictions is published through the National  
1471 Association of Insurance Commissioners' committee process. The  
1472 commissioner's list shall include any reciprocal jurisdiction as defined  
1473 under subparagraphs (A)(i) and (A)(ii) of subdivision (1) of this  
1474 subsection, and shall consider any other reciprocal jurisdiction included  
1475 on the National Association of Insurance Commissioners' list. The  
1476 commissioner may approve a jurisdiction that does not appear on the  
1477 National Association of Insurance Commissioners' list of reciprocal  
1478 jurisdictions in accordance with criteria to be developed under  
1479 regulations adopted by the commissioner in accordance with the  
1480 provisions of chapter 54.

1481 (B) The commissioner may remove a jurisdiction from the list of  
1482 reciprocal jurisdictions upon a determination that the jurisdiction no  
1483 longer meets the requirements of a reciprocal jurisdiction, in accordance  
1484 with a process set forth in regulations adopted by the commissioner  
1485 pursuant to chapter 54, except that the commissioner shall not remove  
1486 from the list a reciprocal jurisdiction as defined under subparagraphs  
1487 (A)(i) and (A)(ii) of subdivision (1) of this subsection. Upon removal of  
1488 a reciprocal jurisdiction from this list, credit for reinsurance ceded to an  
1489 assuming insurer which has its home office or is domiciled in that  
1490 jurisdiction shall be allowed, if otherwise allowed pursuant to this  
1491 section and sections 38a-85a to 38a-88, inclusive, as amended by this act.

1492       (3) The commissioner shall timely create and publish a list of  
1493 assuming insurers that have satisfied the conditions set forth in this  
1494 subsection and to which cessions shall be granted credit in accordance  
1495 with this subsection. The commissioner may add an assuming insurer  
1496 to such list if a National Association of Insurance Commissioners  
1497 accredited jurisdiction has added such assuming insurer to a list of such  
1498 assuming insurers or if, upon initial eligibility, the assuming insurer  
1499 submits the information to the commissioner as required under  
1500 subparagraph (D) of subdivision (1) of this subsection and complies  
1501 with any additional requirements that the commissioner may impose by  
1502 regulation, except to the extent that they conflict with an applicable  
1503 covered agreement.

1504       (4) If the commissioner determines that an assuming insurer no  
1505 longer meets one or more of the requirements under this subsection, the  
1506 commissioner may revoke or suspend the eligibility of the assuming  
1507 insurer for recognition under this subsection in accordance with  
1508 procedures set forth in regulation.

1509       (A) While an assuming insurer's eligibility is suspended, no  
1510 reinsurance agreement issued, amended or renewed after the effective  
1511 date of the suspension qualifies for credit except to the extent that the  
1512 assuming insurer's obligations under the contract are secured in  
1513 accordance with section 38a-86.

1514       (B) If an assuming insurer's eligibility is revoked, no credit for  
1515 reinsurance may be granted after the effective date of the revocation  
1516 with respect to any reinsurance agreements entered into by the  
1517 assuming insurer, including reinsurance agreements entered into prior  
1518 to the date of revocation, except to the extent that the assuming insurer's  
1519 obligations under the contract are secured in a form acceptable to the  
1520 commissioner and consistent with the provisions of section 38a-86.

1521       (5) If subject to a legal process of rehabilitation, liquidation or  
1522 conservation, as applicable, the ceding insurer, or its representative,  
1523 may seek and, if determined appropriate by the court in which the

1524 proceedings are pending, may obtain an order requiring that the  
1525 assuming insurer post security for all outstanding ceded liabilities.

1526 (6) Nothing in this subsection shall limit or in any way alter the  
1527 capacity of parties to a reinsurance agreement to agree on requirements  
1528 for security or other terms in that reinsurance agreement, except as  
1529 expressly prohibited by this section and sections 38a-85a to 38a-88,  
1530 inclusive, as amended by this act, or other applicable law or regulation.

1531 (7) Credit may be taken under this subsection only for reinsurance  
1532 agreements entered into, amended or renewed on or after October 1,  
1533 2021, and only with respect to losses incurred and reserves reported on  
1534 or after the later of the date on which the assuming insurer has met all  
1535 eligibility requirements pursuant to subdivision (1) of this subsection,  
1536 and the effective date of the new reinsurance agreement, amendment or  
1537 renewal.

1538 (A) This subsection does not alter or impair a ceding insurer's right  
1539 to take credit for reinsurance, to the extent that credit is not available  
1540 under this subsection, as long as the reinsurance qualifies for credit  
1541 under any other applicable provision of this section or sections 38a-85a  
1542 to 38a-88, inclusive, as amended by this act.

1543 (B) Nothing in this subsection shall authorize an assuming insurer to  
1544 withdraw or reduce the security provided under any reinsurance  
1545 agreement except as permitted by the terms of the agreement.

1546 (C) Nothing in this subsection shall limit, or in any way alter, the  
1547 capacity of parties to any reinsurance agreement to renegotiate the  
1548 agreement.

1549 [(g)] (h) Credit shall be allowed when the reinsurance is ceded to an  
1550 assuming insurer not meeting the requirements of subsection (b), (c),  
1551 (d), (e), [or] (f) or (g) of this section but only with respect to the insurance  
1552 of risks located in jurisdictions where such reinsurance is required by  
1553 applicable law or regulation of that jurisdiction.

1554 [(h)] (i) If the assuming insurer is not licensed, accredited or certified  
1555 to transact insurance or reinsurance in this state, the credit permitted by  
1556 subsection (d) or (e) of this section shall not be allowed unless the  
1557 assuming insurer agrees (1) that in the event of the failure of the  
1558 assuming insurer to perform its obligations under the terms of the  
1559 reinsurance agreement, the assuming insurer, at the request of the  
1560 ceding insurer, shall (A) submit to the jurisdiction of any court of  
1561 competent jurisdiction in any state of the United States, (B) comply with  
1562 all requirements necessary to give such court jurisdiction, and (C) abide  
1563 by the final decision of such court or any appellate court in the event of  
1564 an appeal, and (2) to designate the commissioner or a designated  
1565 attorney as its true and lawful attorney upon whom may be served any  
1566 lawful process in any action, suit or proceeding instituted by or on  
1567 behalf of the ceding company. This provision is not intended to conflict  
1568 with or override the obligation of the parties to a reinsurance agreement  
1569 to arbitrate their disputes, if such an obligation is created in the  
1570 agreement.

1571 [(i)] (j) If the assuming insurer does not meet the requirements of  
1572 subsection (b), (c), [or] (d) or (g) of this section, the credit permitted by  
1573 subsection (e) or (f) of this section shall not be allowed unless the  
1574 assuming insurer agrees to the following conditions in the trust  
1575 instrument:

1576 (1) Notwithstanding any provision of the trust instrument, if the trust  
1577 contains an amount less than the amount required under subdivision (3)  
1578 of subsection (e) of this section or if the grantor of the trust has been  
1579 declared insolvent or placed in receivership, rehabilitation, liquidation  
1580 or a similar proceeding under the laws of its state or country of domicile,  
1581 the trustee shall comply with an order of the insurance regulatory  
1582 official with principal regulatory oversight of the trust or with an order  
1583 of a court of competent jurisdiction that directs the trustee to transfer all  
1584 trust assets to the insurance regulatory official with principal regulatory  
1585 oversight of the trust;

1586 (2) The trust assets shall be distributed by and claims filed with and

1587 valued by the insurance regulatory official with principal regulatory  
1588 oversight of the trust in accordance with the laws of the trust's state of  
1589 domicile that are applicable to the liquidation of domestic insurance  
1590 companies;

1591 (3) The trustee shall distribute any trust assets or part thereof that are  
1592 returned by the insurance regulatory official with principal regulatory  
1593 oversight of the trust, based on such regulatory official's determination  
1594 that such assets or part thereof are not necessary to satisfy the claims of  
1595 domestic and foreign ceding insurers of the grantor of the trust, in  
1596 accordance with the trust instrument; and

1597 (4) The grantor of the trust waives any right otherwise available to  
1598 the grantor under law that is inconsistent with subdivisions (1) to (3),  
1599 inclusive, of this subsection.

1600 [(j)] (k) (1) (A) The commissioner may suspend or revoke a reinsurer's  
1601 accreditation or certification if, after notice and hearing, the  
1602 commissioner finds such reinsurer no longer meets the requirements for  
1603 accreditation or certification.

1604 (B) If a certified reinsurer's domiciliary jurisdiction ceases to be a  
1605 qualified jurisdiction, as set forth in section 38a-85a, the commissioner  
1606 may suspend the reinsurer's certification indefinitely, in lieu of  
1607 revocation.

1608 (2) The commissioner may suspend or revoke a reinsurer's  
1609 accreditation or certification without notice and a hearing if:

1610 (A) The reinsurer waives its right to a hearing;

1611 (B) The commissioner's action is based on (i) regulatory action taken  
1612 by a regulatory official of the reinsurer's state of domicile, or (ii) the  
1613 voluntary surrender or termination of the reinsurer's eligibility to  
1614 transact the business of insurance or reinsurance in its state of domicile  
1615 or its primary certifying jurisdiction as described in subdivision (2) of  
1616 subsection (a) of section 38a-85a; or

1617 (C) The commissioner finds that immediate action is required to  
1618 protect the public and a court of competent jurisdiction has not stayed  
1619 the commissioner's action.

1620 (3) (A) While a reinsurer's accreditation or certification is suspended,  
1621 no credit shall be allowed under this section for a reinsurance contract  
1622 issued or renewed by the reinsurer on or after the effective date of such  
1623 suspension, except to the extent that such reinsurer's obligations under  
1624 such contract are secured in accordance with the provisions of section  
1625 38a-86.

1626 (B) If a reinsurer's accreditation or certification is revoked, no credit  
1627 shall be allowed under this section on and after the effective date of such  
1628 revocation, except to the extent that such reinsurer's obligations under  
1629 such contract are secured in accordance with the provisions of  
1630 subsection (e) of section 38a-85a or section 38a-86.

1631 (4) A reinsurer whose certification has been suspended, revoked or  
1632 voluntarily surrendered or is inactive shall be treated as a certified  
1633 reinsurer required to secure one hundred per cent of its obligations,  
1634 except that this requirement shall not apply to a reinsurer whose  
1635 certification has been suspended or is inactive if the commissioner  
1636 continues to assign a high rating to such reinsurer pursuant to section  
1637 38a-85a.

1638 (5) Any person aggrieved by the action of the commissioner in  
1639 revoking or suspending an accreditation or a certification may appeal  
1640 therefrom in accordance with the provisions of section 38a-19.

1641 [(k)] (l) (1) A domestic ceding insurer shall manage its reinsurance  
1642 recoverables in proportion to its own book of business. Such insurer  
1643 shall notify the commissioner not later than thirty days after (A)  
1644 reinsurance recoverables from any single assuming insurer or group of  
1645 affiliated assuming insurers exceed fifty per cent of the domestic ceding  
1646 insurer's last reported surplus to policyholders, or (B) the domestic  
1647 ceding insurer determines that reinsurance recoverables from any single  
1648 assuming insurer or group of affiliated assuming insurers are likely to

1649 exceed such limit. Any such notice shall demonstrate that the exposure  
1650 is safely managed by the domestic ceding insurer.

1651 (2) A ceding insurer shall manage its reinsurance program to ensure  
1652 diversification. A domestic ceding insurer shall notify the commissioner  
1653 not later than thirty days after (A) it has ceded to any single assuming  
1654 insurer or group of affiliated assuming insurers more than twenty per  
1655 cent of the domestic ceding insurer's gross written premiums in the  
1656 prior calendar year, or (B) the domestic ceding insurer determines that  
1657 the reinsurance ceded to any single assuming insurer or group of  
1658 affiliated assuming insurers is likely to exceed such limit. Any such  
1659 notice shall demonstrate that the exposure is safely managed by the  
1660 domestic ceding insurer.

1661 Sec. 7. Subdivision (9) of subsection (a) of section 38a-25 of the general  
1662 statutes is repealed and the following is substituted in lieu thereof  
1663 (*Effective October 1, 2021*):

1664 (9) Insurance companies designating the Insurance Commissioner as  
1665 agent for receipt of service of process pursuant to subsection [(h)] (i) of  
1666 section 38a-85, as amended by this act.

1667 Sec. 8. Subparagraph (C) of subdivision (2) of subsection (a) of section  
1668 38a-92m of the general statutes is repealed and the following is  
1669 substituted in lieu thereof (*Effective October 1, 2021*):

1670 (C) An insurer not licensed in this state but that is licensed in, or in  
1671 the case of a United States branch of an alien insurer, is entered through,  
1672 a state that employs standards regarding credit for reinsurance  
1673 applicable to financial guaranty insurance corporations that are  
1674 substantially similar to those in this state and the assuming insurer or  
1675 United States branch of the alien insurer: (i) Otherwise complies with  
1676 the provisions of subparagraphs (B)(i) and (B)(ii) of this subdivision; (ii)  
1677 submits to the authority of this state to examine its books and records;  
1678 and (iii) meets the requirements of subsection [(h)] (i) of section 38a-85,  
1679 as amended by this act;

1680 Sec. 9. Subsection (b) of section 38a-88 of the general statutes is  
1681 repealed and the following is substituted in lieu thereof (*Effective October*  
1682 *1, 2021*):

1683 (b) (1) The commissioner may adopt regulations in accordance with  
1684 the provisions of chapter 54 to establish, in addition to the requirements  
1685 of sections 38a-85, as amended by this act, and 38a-86, requirements  
1686 relating to or setting forth (A) the valuation of assets or reserve credits,  
1687 (B) the circumstances under which credit will be reduced or eliminated,  
1688 and (C) the amounts and forms of security supporting reinsurance  
1689 agreements relating to (i) life insurance policies with guaranteed  
1690 nonlevel gross premiums or guaranteed nonlevel benefits, (ii) universal  
1691 life insurance policies with provisions that permit a policyholder to keep  
1692 such policy in force over a secondary guarantee period, (iii) variable  
1693 annuities with guaranteed death or living benefits, (iv) long-term care  
1694 insurance policies, or (v) any other life insurance, health insurance or  
1695 annuity products for which the National Association of Insurance  
1696 Commissioners adopts model regulatory credit for reinsurance  
1697 requirements.

1698 (2) Any regulation adopted pursuant to subdivision (1) of this  
1699 subsection that relates to policies described in subparagraph (C)(i) or  
1700 (C)(ii) of subdivision (1) of this subsection may apply to reinsurance  
1701 agreements that include such policies issued on or after January 1, 2015,  
1702 and such policies issued prior to January 1, 2015, if risk pertaining to  
1703 such policies is ceded, in whole or in part, in connection with such  
1704 agreement on or after January 1, 2015.

1705 (3) Any regulations adopted pursuant to subdivision (1) of this  
1706 subsection [:(A) May] may require the ceding insurer, in calculating the  
1707 amounts or forms of security supporting reinsurance agreements, to use  
1708 the Valuation Manual, as defined in section 38a-78, in effect on the date  
1709 such calculation is made, to the extent applicable. [; and]

1710 [(B)] (4) [Shall] Any regulation adopted pursuant to this subsection  
1711 shall not apply to cessions to an assuming insurer [(i)] that (A) meets the



1712 conditions set forth in subsection (g) of section 38a-85, as amended by  
1713 this act, (B) is certified as a reinsurer in accordance with the provisions  
1714 of section 38a-85a, or [(ii) (I) that] (C) maintains at least two hundred  
1715 fifty million dollars in capital and surplus, determined in accordance  
1716 with the National Association of Insurance Commissioners Accounting  
1717 Practices and Procedures Manual, including all amendments adopted  
1718 by the National Association of Insurance Commissioners and excluding  
1719 the impact of any permitted or prescribed practices, and [(II)] (i) is  
1720 licensed in at least twenty-six states, or (ii) is licensed in at least ten states  
1721 and licensed or accredited in a total of at least thirty-five states.

1722 (5) The authority to adopt regulations pursuant to this subsection  
1723 does not limit the commissioner's general authority to adopt regulations  
1724 pursuant to subsection (a) of this section.

1725 Sec. 10. Subsection (k) of section 38a-660 of the general statutes is  
1726 repealed and the following is substituted in lieu thereof (*Effective October*  
1727 *1, 2021*):

1728 (k) (1) (A) To further the enforcement of this section and sections 38a-  
1729 660b to 38a-660m, inclusive, as amended by this act, and to determine  
1730 the eligibility of any licensee, the commissioner may, as often as the  
1731 commissioner deems necessary, examine the books and records of any  
1732 such licensee. Each person licensed as a surety bail bond agent in this  
1733 state shall, on or before January thirty-first, annually, pay to the  
1734 commissioner a fee of four hundred fifty dollars to cover the cost of  
1735 examinations under this subsection.

1736 (B) If such person fails to pay such fee on or before January thirty-  
1737 first, annually, the license of such person shall automatically expire on  
1738 the February first immediately following, provided the commissioner  
1739 shall immediately reinstate any such license if the commissioner  
1740 receives such fee not later than thirty days after such expiration.

1741 (C) The commissioner shall notify, not later than December fifteenth,  
1742 annually, each person licensed as a surety bail bond agent in this state  
1743 about such automatic expiration provision.

1744 (2) The fees received by the commissioner pursuant to subdivision (1)  
 1745 of this subsection shall be dedicated to conducting the examinations  
 1746 under said subdivision (1) and shall be deposited in the account  
 1747 established under subdivision (3) of this subsection.

1748 (3) There is established an account to be known as the "surety bail  
 1749 bond agent examination account", which shall be a separate account  
 1750 within the Insurance Fund established under section 38a-52a. The  
 1751 account shall contain any moneys required by law to be deposited in the  
 1752 account and any such moneys remaining in the account at the [close of  
 1753 the fiscal] end of each calendar year shall be transferred to the General  
 1754 Fund.

1755 Sec. 11. Section 38a-660m of the general statutes is repealed and the  
 1756 following is substituted in lieu thereof (*Effective October 1, 2021*):

1757 The commissioner may adopt regulations, in accordance with the  
 1758 provisions of chapter 54, to (1) implement the provisions of section 38a-  
 1759 660, as amended by this act, and sections 38a-660b to 38a-660k, inclusive,  
 1760 and (2) establish continuing education requirements for persons  
 1761 licensed as surety bail bond agents in this state.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2021</i>	19a-7p(b) and (c)
Sec. 2	<i>from passage</i>	38a-12
Sec. 3	<i>from passage</i>	38a-38(b) to (g)
Sec. 4	<i>July 1, 2021</i>	38a-48(g)
Sec. 5	<i>October 1, 2021</i>	38a-591g
Sec. 6	<i>October 1, 2021</i>	38a-85
Sec. 7	<i>October 1, 2021</i>	38a-25(a)(9)
Sec. 8	<i>October 1, 2021</i>	38a-92m(a)(2)(C)
Sec. 9	<i>October 1, 2021</i>	38a-88(b)
Sec. 10	<i>October 1, 2021</i>	38a-660(k)
Sec. 11	<i>October 1, 2021</i>	38a-660m

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

**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 22 \$	FY 23 \$
Insurance Dept.	GF - Potential Revenue Gain	Minimal	Minimal
Insurance Dept.	IF - Net Savings	2,550	3,400

Note: GF=General Fund; IF=Insurance Fund

**Municipal Impact:** None

**Explanation**

The bill makes a variety of changes to the insurance statutes that result in the fiscal impacts described below.

**Section 1** results in a potential minimal revenue gain to the General Fund from additional penalties and fines related to the Public Health Fee. Under the bill, the Insurance Commissioner may assess a civil fine of up to \$15,000 on insurers and HMO's that intentionally misrepresent the number of covered lives under their policies. The bill also establishes a late filing fee of \$100 per day. As the Insurance Department (DOI) does not have issues with the accurate and timely submission by insurers and HMO's for the Public Health Fee, there is minimal, if any, new revenue anticipated from these provisions.

**Sections 2 and 3** make technical changes to the insurance data security law and repeal a reporting requirement for the Insurance Commissioner, both of which have no fiscal impact. For the annual report being repealed, neither the information it is intended to report about nor the report itself has been submitted in recent years.

**Section 4** allows domestic insurance companies to pay their entire

share of the Insurance Fund General Assessment at the first payment date rather than quarterly, which may bring forward some Insurance Fund revenue but does not change the total revenue amount to be received by the fund.

**Section 5** results in a net savings for DOI of approximately \$3,400 per year due to the elimination of the \$25 external review application fee because the agency currently spends more on fee administration than it gains in revenue. For example, DOI collected \$5,759 in such fees in 2020 but had to return fees worth \$3,800 because the fee is waived in certain cases. The resulting fee revenue in 2020 of \$1,959 was more than offset by the \$5,340 incurred by DOI in administrative costs for the handling of initial and returned checks.<sup>1</sup> The FY 22 fiscal impact reflects nine months of net savings.

**Sections 6 to 9** eliminate reinsurance collateral requirements for “reciprocal” reinsurers in certain jurisdictions to bring Connecticut into compliance with agreements signed at the national level with the European Union and the United Kingdom. These provisions are not anticipated to have a fiscal impact, as DOI has the necessary staff and expertise to implement the changes and update regulations in accordance with the bill.

**Sections 10 and 11** make changes related to the regulation of surety bail bond agents, including preventing licensees from delaying payment of the annual licensing fee. These changes have no fiscal impact as they do not change the annual licensing fee collected but rather prevent a delay in such payments (currently licensees are able to delay renewal payment by several months) and the Insurance Commissioner already sends expiration date reminders. Additionally, there is no anticipated fiscal impact from establishing continuing education requirements for surety bail bond agents, as permitted under the bill, because any such program would likely be structured so that licensees incur any costs.

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<sup>1</sup> According to DOI, they incur a cost of \$10 per check for initial fees and \$20 per check for refunds.

House "A" adds the credit for reinsurance and surety bail bond agent provisions and does not change the fiscal impact of the bill.

***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to the amount of applications for external review and any penalties related to the Public Health Fee assessed.

*Sources: Connecticut Insurance Department*

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**OLR Bill Analysis****sHB 6391 (as amended by House "A")\******AN ACT CONCERNING THE INSURANCE DEPARTMENT'S  
RECOMMENDATIONS REGARDING THE GENERAL STATUTES.*****SUMMARY**

This bill:

1. changes the adverse determination process, including (a) eliminating a filing fee for external and expedited external adverse determination reviews and (b) requiring health carriers, and not the commissioner, to notify covered individuals about these reviews (§ 5);
2. makes several changes to the Insurance Data Security Law, which generally requires insurers and other entities regulated by the insurance department to inform the department and insureds of cybersecurity breaches, including by (a) clarifying that the law's scope is limited to breaches of nonpublic information; (b) delaying implementation of several provisions by one year; (c) imposing deadlines by which certain exempt entities must submit certification to the commissioner; and (d) changing which entities must notify the commissioner and insureds, and the circumstances under which they must do so (§ 3);
3. requires health care centers (i.e., HMOs) and insurers to provide documentation to the insurance commissioner, upon his request, substantiating the number of lives they cover or insure as annually reported and allows the commissioner to fine HMOs and insurers (a) who fail to comply by the statutory deadline or (b) if he finds data discrepancies not attributable to good faith mistakes (§ 1);

4. aligns Connecticut's insurance laws with the National Association of Insurance Commissioners' (NAIC) 2019 amendments to its "Credit for Reinsurance Model Law," to (a) avoid federal preemption and (b) conform to agreements between the United States and the European Union and United Kingdom, which were entered into pursuant to federal law (§§ 6-9);
5. changes the insurance statutes relating to surety bail bond agents, including by (a) establishing an automatic license expiration process for when a surety bail bond agent fails to pay the required annual \$450 examination fee; (b) changing when money in the surety bail bond examination account is transferred to the General Fund at the end of the calendar year, instead of the end of the fiscal year; and (c) authorizing the insurance commissioner to adopt regulations establishing continuing education requirements for surety bail bond agents (§§ 10 & 11);
6. repeals a requirement for the insurance commissioner to annually submit a report to the Insurance and Real Estate Committee containing information he has received related to (a) fires caused by arson, (b) workers' compensation fraud unit quarterly reports, (c) motor vehicle insurance fraud, and (d) health insurance fraud (§ 2); and
7. allows insurers, in their discretion, to pay the insurance fund assessment at once when the first installment is due on June 30, instead of quarterly (§ 4). (By law, the insurance department assesses domestic insurers to fund the department, Office of Health Strategy, Office of Healthcare Advocate, and the Department of Rehabilitation Services' fall prevention program.)

The bill also makes numerous minor, technical, and conforming changes.

\*House Amendment "A" adds the credit for reinsurance (§§ 6-9) and surety bail bond agent (§§ 10 & 11) provisions.

EFFECTIVE DATE: July 1, 2021, except the provisions changing the data security law and repealing the insurance commissioner reporting requirement are effective upon passage, and the adverse determination, credit for reinsurance, and surety bail bond agent provisions are effective October 1, 2021.

## **§ 5 — EXTERNAL REVIEW PROCESS**

### ***Filing Fee***

The bill eliminates the \$25 filing fee that must accompany a request for an external or expedited external adverse determination review. Under current law, the fee is (1) waived if the commissioner finds the covered person is indigent or unable to pay, and (2) returned if the review is overturned.

### ***Process and Deadlines***

The bill requires the commissioner to assign an independent review organization (IRO) within one business day after receiving a complete request for expedited external adverse determination review, instead of one calendar day after it. Existing law requires him to meet this same deadline for external adverse determination reviews that are not expedited.

The bill also requires health carriers, instead of the commissioner, to notify covered individuals or their representatives of (1) an accepted external or expedited external adverse determination request and (2) where and how to send additional information. The bill also requires health carriers to notify the commissioner. By law, a covered person or their representative must be notified that they may submit additional information to the IRO within five business days. An IRO must consider any information it receives in this timeframe and may consider information received after it. (Existing law requires carriers to notify the commissioner and the covered individual of whether the review is accepted within one business day.)

Lastly, the bill requires health carriers to provide the necessary health information to the IRO within five business days (for an external review)



or one calendar day (for an expedited external review), beginning when they accept the review instead of when they receive the IRO's name from the commissioner.

### **§ 3 — DATA SECURITY LAW**

The bill makes several changes to the state Insurance Data Security Law (CGS § 38a-38).

#### ***Applicability***

The bill clarifies that the insurance data security law only applies to cyber security events resulting in unauthorized access to nonpublic, rather than any, information. Under current law, "nonpublic information" is information that is not publicly available and that:

1. concerns a consumer's name, number, or other identifiable information that can identify a consumer when used in combination with an access or security code to a consumer's financial account; account, credit, or debit card number; biometric records; driver's license or nondriver identification number; or Social Security number;
2. would materially impact a licensee's business, operation, or security if disclosed or used without authorization; or
3. is created or derived from a consumer or health care provider and concerns behavioral, mental, or physical health, or health care services or payments.

Under the bill, nonpublic information is electronic data and information that meets the above criteria. As under existing law, nonpublic information excludes a consumer's age or gender.

The bill also explicitly applies the law's requirements to fraternal benefit societies, interlocal risk management agencies, or employers' mutual associations. (These organizations are exempt from certain other insurance laws.) But it exempts from the law any Superior Court commissioner acting as a title agent.

***New York Requirement Compliance.*** Under current law, licensees that comply with another jurisdiction approved by the commissioner and annually submit to the commissioner a written statement certifying compliance are deemed to have satisfied data security requirements. The bill limits this so that only licensees that comply with New York's Cybersecurity Requirements for Financial Services Companies regulations (23 NYCRR 500) are deemed to have satisfied the law's requirements. The bill also moves the deadline for the annual written statement from February 15 to April 15.

***Annual Certification***

The bill requires domiciled health care centers and fraternal benefit societies, including those that are part of an insurance holding company system, to comply with the law's annual certification, record retention, and remediation requirements.

***Certification and Record Retention.*** By law, insurers and others covered by the bill and law must submit to the commissioner a written statement certifying that the insurer has complied with the law's risk assessment and information security program provisions. Each applicable entity must maintain all supporting documents for examination, including data, records, and schedules, for at least five years after submitting its certification. For all covered entities, the bill requires this certification by April 15, instead of February 15.

The bill also allows a domestic insurer, HMO, or fraternal benefit society that is a member of an insurance holding company system to submit one certification statement on behalf of all the holding company members.

***Remediation.*** Existing law requires insurers that identify areas, processes, or systems that require material improvements, redesigns, or updates to (1) document and identify the remediation efforts planned and underway and (2) make the documents available to the commissioner on request. The bill extends this requirement to HMOs and fraternal benefit societies and specifies that companies may comply

directly or through an affiliate.

### ***Delayed Implementation***

The bill delays by one year, until October 1, 2021, the deadline for insurers and other covered entities to implement an information security program. By law, information security programs must, among other things, (1) contain administrative, technical, and physical safeguards to protect nonpublic information and the company's information systems and (2) define, and periodically reevaluate, a schedule for retaining nonpublic information and a mechanism to destroy this information when it is no longer needed.

It also delays, by one year, until October 1, 2022, the date by which insurers and other covered entities must require third-party service providers to implement appropriate measures to protect data and nonpublic information.

It also delays, by one year, the period during which certain small licensees are exempt from the law's requirements. Current law exempts (1) from October 1, 2020, to September 30, 2021, licensees with fewer than 20 employees and (2) after October 1, 2021, licensees with fewer than 10 employees. Under the bill, the exempt periods are October 1, 2021, to September 30, 2022, and after October 1, 2022, respectively.

### ***HIPAA Certification***

Licensees subject to, and that certify to the commissioner they comply with, the federal Health Insurance Portability and Accountability Act are deemed to have satisfied the state data security requirements. The bill requires this certification to be submitted annually by April 15.

### ***Cyber Security Event Notification***

Current law requires licensees to notify the commissioner within three business days after a cybersecurity event and report certain related information. The bill specifies that a licensee must notify the commissioner within three business days after first determining that a cybersecurity event occurred and correspondingly adds the date on

which the cybersecurity event was discovered to the information that must be reported.

It also requires the licensee to report the total number of consumers residing in Connecticut that, to the licensee's knowledge at the time of the report, are impacted by the cybersecurity event. Current law requires a licensee to report the total number of impacted Connecticut consumers.

Under current law, certain licensed insurance producers and domestic insurers must notify the insurance commissioner of a cybersecurity event if they:

1. reasonably believe that the nonpublic information involved in the cybersecurity event affects at least 250 Connecticut residents and
2. (a) must send a cybersecurity notice to any governing, regulatory, or supervisory body under federal or state law or (b) it is reasonably likely the cybersecurity event will materially harm a Connecticut consumer or the licensee's business.

The bill establishes different reporting requirements for domestic insurers and Connecticut insurance producers. These entities must report a cybersecurity event if it is reasonably likely that the event will materially harm a Connecticut consumer or the licensee's business.

The bill extends existing notification requirements to any licensee that:

1. reasonably believes that the nonpublic information involved in the cybersecurity event affects at least 250 Connecticut residents and
2. (a) must send a cybersecurity notice to any governing, regulatory, or supervisory body under federal or state law or (b) it is reasonably likely the cybersecurity event will materially harm any Connecticut consumer or the licensee's business.

The bill also changes how the reporting deadline is calculated for cybersecurity events of third-party service providers. Under the bill, it begins with the first day after a licensee has actual knowledge of a cybersecurity event, instead of when they become aware of it.

### ***Confidential Information***

By law, material and other information provided to the commissioner is confidential and privileged, and exempt from disclosure under the state's Freedom of Information Act and any subpoena or discovery in a private cause of action. However, the commissioner may share this information with certain other parties, including the National Association of Insurance Commissioners (NAIC). The bill extends this confidentiality to all materials and information provided to, or in custody or control of, NAIC or a third-party consultant.

### ***Commissioner Authority***

The bill allows the commissioner to, after a hearing, take any action necessary or appropriate to enforce the law's provisions. By law, he may suspend or revoke a license and impose a civil fine, among other actions.

## **§ 1 — REPORTING REQUIREMENTS AND PENALTIES**

By law, all domestic HMOs and insurers must report annually to the commissioner on the number of Connecticut lives they insure or enroll. This data is used to calculate the public health fee they must pay. The bill allows the commissioner to require each HMO or insurer, or any other appropriate person, to submit any records the HMO, insurer, or person possesses that were used to prepare the annual report.

The bill allows the commissioner to assess an insurer or HMO a civil fine of up to \$15,000 if he determines that there is a discrepancy, other than in good faith, between the actual number of covered lives and the reported number. By law, anyone aggrieved by a commissioner's decision may request a hearing and, if necessary, appeal the decision to Superior Court under the Uniform Administrative Procedure Act (CGS § 38a-19).

The bill also establishes a \$100 per day penalty, in a form and manner the commissioner prescribes, for failing to submit the report by the statutorily required September 1 deadline.

These provisions are applicable to HMOs and insurers that provide policies covering (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

### **§§ 6-9 — CREDIT FOR REINSURANCE**

The bill aligns Connecticut's insurance laws with the National Association of Insurance Commissioners' (NAIC) 2019 amendments to its "Credit for Reinsurance Model Law." It does so to (1) avoid federal preemption and (2) conform to agreements between the United States and the European Union and United Kingdom (together, the "covered agreements"), which were entered into pursuant to federal law. These agreements eliminate collateral requirements as a condition for entering into a reinsurance agreement with a Connecticut-domiciled insurer or allowing the insurer to recognize credit for reinsurance.

Under existing state law, an insurer may count reinsurance as a credit for an asset or a reduction for a liability on certain financial statements, including annual reports to the insurance commissioner, if the reinsurer meets specified statutory requirements pertaining to minimum surplus, licensing, filing, and examinations. Reinsurance is a transaction in which an insurance company transfers a portion of risk (the ceding insurer) to another insurance company (the assuming insurer or reinsurer) so that a large loss does not fall on any one company.

The bill specifies that, in general, credit for reinsurance is allowed only with respect to cessions for the kinds or classes of business which the assuming insurer is licensed or permitted to write or assume in its domiciliary state or, if it is an insurer in another country (i.e., alien insurer), the state in which it is licensed to transact insurance or reinsurance.

The bill also allows credit for reinsurance when the reinsurance is ceded to an assuming insurer that meets newly specified criteria as described below. The assuming insurer must comply with any related regulations the commissioner adopts.

The bill requires the commissioner to publish a list of assuming insurers that meet all conditions set forth in statute and to which cessions will be granted credit for reinsurance. It authorizes him to revoke or suspend an assuming insurer's eligibility in accordance with regulations if the insurer no longer meets the statutory requirements. After a suspension or revocation, no credit for reinsurance is generally allowed, except to the extent that they have been secured in accordance with state law.

### ***Requirements for Assuming Insurers***

The bill allows credit for reinsurance when the reinsurance is ceded to an assuming insurer that meets specified criteria. Credit may be taken for reinsurance agreements entered into, amended, or renewed on or after October 1, 2021, and only for losses incurred on or after the later of when the assuming insurer meets all requirements and the agreement's effective date.

The bill requires an assuming insurer to have its head office or be domiciled in, as applicable, and licensed in, a reciprocal jurisdiction. A "reciprocal jurisdiction" is (1) a non-U.S. jurisdiction subject to a covered agreement; (2) an NAIC-accredited U.S. jurisdiction; or (3) a qualified jurisdiction that meets requirements consistent with the covered agreements, as specified in regulations the commissioner adopts. The bill requires the commissioner to publish a list of reciprocal jurisdictions, for which he must consider NAIC's list of reciprocal jurisdictions. It authorizes him to remove a jurisdiction from his list if it no longer meets the requirements of a reciprocal jurisdiction.

Under the bill, an assuming insurer, among other things, must maintain minimum capital and surplus, or its equivalent, and a minimum solvency or capital ratio, all of which the commissioner is to

set forth in regulations. If the assuming insurer is an association, it also must maintain a central fund with a balance in amounts set forth in regulations. The bill requires the assuming insurer's supervisory authority to confirm annually to the commissioner that the insurer complies with these requirements.

Under the bill, an assuming insurer must also give the commissioner certain assurances in a manner the commissioner specifies in regulations, including that it will:

1. give prompt notice if it falls below the minimum requirements or if any regulatory action is taken against it for serious noncompliance with applicable law;
2. consent to the jurisdiction of the state's courts and appoint the commissioner as agent for service of process, but parties to a reinsurance agreement may agree to alternative dispute resolution mechanisms, so long as they are enforceable under applicable laws;
3. pay all final enforceable judgements obtained by a ceding insurer; and
4. provide security of 100% of the assuming insurer's liabilities attributable to the ceded reinsurance.

Additionally, the assuming insurer must confirm that it is not participating in any "solvent scheme of arrangement" with the state's ceding insurers and agree to notify the commissioner and the ceding insurer if it enters into one. In that case, the assuming insurer must provide security of 100% of the assuming insurer's liabilities to the ceding insurer.

The bill requires the assuming insurer to comply with any related regulations the commissioner adopts, including those about paying claims promptly and providing the commissioner with documentation upon request. It specifies that it does not preclude an assuming insurer



from providing the commissioner information voluntarily.

## **§§ 10 & 11 — SURETY BAIL BOND AGENTS**

A surety bail bond agent sells bail bonds in criminal cases through a contract with an insurer. The insurance commissioner licenses and regulates the agents.

### ***License Expiration Process***

Under the bill, a surety bail bond agent's license expires on February 1 if the agent fails to pay the required annual \$450 examination fee by January 31. But if the agent pays the fee within 30 days after the expiration, the commissioner must immediately reinstate the agent's license. The bill requires the commissioner to notify each agent of the expiration provision annually by December 15.

Under current law, the commissioner follows procedures under the Uniform Administrative Procedure Act when an agent fails to pay the fee by the deadline, which allows for an extended timeframe for adjudicating these issues.

### ***Transfer of Account Money***

By law, examination fees are deposited in the surety bail bond examination account, which is an account within the Insurance Fund that the commissioner uses to pay the costs of examining agents' books and records. The bill changes when money remaining in the account is transferred to the General Fund from the end of the fiscal year to the end of the calendar year. So, it allows him access to the money for a longer period of time than under current law.

## **COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 18    Nay 0    (03/22/2021)