PA 21-157—sHB 6391
Insurance and Real Estate Committee

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

SUMMARY: This act makes various unrelated changes in the insurance statutes. It:

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, rather than the insurance 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 (a) clarifying that the law's scope is limited to breaches of nonpublic information; (b) delaying implementation of certain information security 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, that substantiates the number of lives they reported covering or insuring in their annual reports, and allows the commissioner to fine HMOs and insurers (a) who fail to comply by the statutory deadline or (b) whose annual reports contain 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" thus (a) avoiding federal preemption and (b) conforming 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, to, among other things, (a) establish an automatic license expiration process for when a surety bail bond agent fails to pay the required annual $450 examination fee; (b) require that money in the surety bail bond examination account be transferred to the General Fund at the end of the calendar year, instead of the end of the fiscal year; and (c) authorize the insurance commissioner to adopt regulations establishing continuing education requirements for surety bail bond agents (§§ 10 & 11);

6. repeals the requirement that the insurance commissioner 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 in full when the first installment is due on June 30, instead of quarterly (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) (§ 4).

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

EFFECTIVE DATE: October 1, 2021, except the HMO and insurer reporting provisions (§ 1) and insurance fund assessment payment provision (§ 4) are effective July 1, 2020, and the provisions changing the data security law (§ 3) and repealing the insurance commissioner reporting requirement (§ 2) are effective upon passage.

§ 5 — EXTERNAL REVIEW PROCESS

By law, a covered person or his or her authorized representative may request, in certain circumstances, that an independent review organization (IRO) conduct an external review of an adverse determination from his or her health carrier.

Filing Fee

The act eliminates the requirement that covered individuals submit a $25 filing fee with their request for an external or expedited external adverse determination review. Under prior law, the fee was (1) waived if the commissioner found the covered person was indigent or unable to pay and (2) returned if the review was overturned.

Process and Deadlines

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

The act also requires health carriers, instead of the commissioner, to notify covered individuals, or their representatives, and the commissioner, about (1) accepted external or expedited external adverse determination requests and (2) where and how covered individuals may submit additional information. 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 act 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) from the date they accept the review instead of the date they receive the IRO's name from the commissioner.

§ 3 — INSURANCE DATA SECURITY LAW

The act makes several changes to the state Insurance Data Security Law's requirements regarding information security programs, security event notification, confidential information, and the commissioner's enforcement authority (CGS § 38a-38).

Covered Data and Entities

The act clarifies that the insurance data security law only applies to cyber security events resulting in unauthorized access to nonpublic, rather than any, information. And it limits "nonpublic information" to electronic information.

As under existing law, nonpublic information is information that:

1. concerns a consumer's name, number, or other identifiable information that can identify the consumer when combined with certain other information (e.g., credit or debit card numbers, biometric records, driver's license 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.

The act 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.

Information Security Program Requirements

Delayed Implementation. The act 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 additionally extends by one year, until September 30, 2022, the grace period during which licensees with fewer than 20 employees are exempt from the law's

information security program requirements. It correspondingly exempts licensees with fewer than 10 employees beginning October 1, 2022, rather than October 1, 2021.

Annual Certification and Record Retention. By law, Connecticut-domiciled insurers must (1) annually submit to the commissioner a written statement certifying that the insurer has complied with the law's risk assessment and information security program provisions and (2) maintain all supporting data, records, and schedules for examination for at least five years after submitting its certification. The act extends these requirements to Connecticut-domiciled HMOs and fraternal benefit societies. For all covered entities, the act requires this certification by April 15, instead of February 15.

The act 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 their planned and underway remediation efforts and (2) make the documents available to the commissioner upon his request. The act extends this requirement to HMOs and fraternal benefit societies and specifies that companies may comply directly or through an affiliate.

Exemption for Health Insurance Portability and Accountability Act (HIPAA) Compliance. Licensees subject to, and that certify to the commissioner they comply with, the federal HIPAA are deemed to have satisfied the law's information security program requirements. The act requires this certification to be submitted annually by April 15.

Exemption for Compliance with Other Jurisdictions' Requirements. Under the prior law, licensees that complied with another, commissioner-approved jurisdiction's requirements, and annually certified that to the commissioner, were deemed to have satisfied the law's information security program requirements. The act limits this exception to licensees that comply with New York's Cybersecurity Requirements for Financial Services Companies regulations (23 NYCRR 500 et seq.). The act also moves the deadline for the annual written statement from February 15 to April 15.

Cyber Security Event Notification

Notification Deadline and Required Information. Prior law required licensees to notify the commissioner within three business days after a cybersecurity event occurred and report certain related information. The act 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.

Expanded Reporting Requirements for Insurers and Connecticut Insurance Producers. The act establishes expanded reporting requirements for domestic insurers and Connecticut insurance producers. Under prior law, these entities had to report a cybersecurity event if certain conditions were met (e.g., the event

impacted at least 250 Connecticut residents). Under the act, 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.

Expanded Notification Requirements for all Licensees. Prior law appeared to limit the commissioner notification requirement to domestic insurers and insurance producers as described above. The act extends the notification requirements to any licensee that reasonably believes that the nonpublic information involved in the cybersecurity event affects at least 250 Connecticut residents if:

1. it must send a cybersecurity notice to any governing, regulatory, or supervisory body under federal or state law or
2. it is reasonably likely the cybersecurity event will materially harm any Connecticut consumer or the licensee's business.

The act 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. Prior law required a licensee to report the total number of impacted Connecticut consumers.

Third-Party Reporting Deadlines. The act also changes how the reporting deadline is calculated for cybersecurity events of third-party service providers. Under the act, 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 act extends this confidentiality and privilege to all materials and information provided to, or in custody or control of, NAIC or a third-party consultant.

Commissioner Authority

The act allows the commissioner, after a hearing, to 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, certain domestic HMOs and insurers must annually report 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 act 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 act 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 one made in good faith, between the actual number of covered lives and the reported number. By law, anyone aggrieved by the commissioner's decision may request a hearing and, if necessary, appeal the decision to the Superior Court under the Uniform Administrative Procedure Act (CGS § 38a-19).

The act also establishes a $100 per day penalty, due 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 act aligns Connecticut's insurance laws with NAIC's 2019 amendments to its "Credit for Reinsurance Model Law." Doing so (1) avoids federal preemption and (2) conforms 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 covered 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 act 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 act 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 act requires the commissioner to publish a list of assuming insurers that meet all conditions specified 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 act allows credit for reinsurance when the reinsurance is ceded to an assuming insurer that is licensed and has its head office, or is domiciled, in a reciprocal jurisdiction. 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.

Under the act, 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 act 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 act, an assuming insurer from a reciprocal jurisdiction must, among other things, maintain minimum capital and surplus, or its equivalent, and a minimum solvency or capital ratio, all of which the commissioner must specify in regulations. If the assuming insurer is an association, it also must maintain a central fund with a balance in amounts specified in regulations. The act requires the assuming insurer's supervisory authority to confirm annually to the commissioner that the insurer complies with these requirements.

Under the act, 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, although parties to a reinsurance agreement may agree to alternative dispute resolution mechanisms if they are enforceable under applicable laws;
3. pay all final enforceable judgements obtained by a ceding insurer; and
4. agree in its reinsurance agreement to provide security equaling 100% of the assuming insurer's liabilities attributable to the ceded reinsurance if the assuming insurer resists the enforcement of an enforceable final judgement or arbitration award.

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 act 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 act, 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 act requires the commissioner to notify each agent of the expiration provision annually by December 15.

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 act 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 the commissioner access to the money for a longer period of time than under prior law.