Legislative Proposals for the 2013 Session
Connecticut Insurance Department

1. AAC Enterprise Risk Reports
    - Fixes the effective due date of the enterprise risk report

2. AAC Consumer Protection Enhancements
    - Prohibits the use of discretionary clauses
    - Provides time frames for claims payments for LTC and DI
    - Requires insurers to retain proof of delivery/ mailing for individual life insurance
    - Grants Department the authority to order restitution

3. AAC Concerning the State's Spending Cap
    - Exempts the Insurance Department from the state's spending cap

4. AAC Revisions to the Insurance Statutes
    - Includes 15 technical corrections that have been in previous revisions bills

5. AAC Standard Valuation Law
    - Updates Standard Valuation Law per recent NAIC activity

6. AAC Solvency Assessment Model (ORSA)
    - Adopt NAIC Risk Management and Own Risk and Solvency Assessment Model

7. AAC Loss Ratio Guarantees
    - Repeals the loss ratio guarantee and 30 day deemer in individual health insurance rating law

8. AAC Service of Process
    - Changes to service of process for foreign and alien insurers/Commissioner named only if an appointed agent cannot be found.

9. AAC Annuity and Long-Term Care
    - Provides opportunity for consumers to have LTC benefits without having to purchase a LTC policy.

10. AAC Catastrophe Dispute Resolution Mechanism
    - Establishes a Catastrophe Dispute Resolution Mechanism

11. AAC Market Conduct Authority
    - Parallels the financial exam statute and allows Department to charge entities for the cost of exams and out-of-state travel.

12. AAC Amusement Park Insurance Certificates
    - Eliminates the Department's involvement in verifying the financial responsibility requirements of pyrotechnic and amusement park events.

13. AAC Home Addresses
    - Provide that the home address of Insurance Department employees is confidential.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Enterprise Risk Report

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

State Agency: Connecticut Insurance Department

Liaison: Debra J. Korta
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Lead agency division requesting this proposal: Financial Regulation Division

Agency Analyst/Drafter of Proposal: Jon Arsenault

Title of Proposal
An Act Concerning the Enterprise Risk Report

Statutory Reference 38a-135

Proposal Summary

The relevant language simply makes it clear that the enterprise risk report that carriers will be required to file with the Insurance Department will be due no earlier than June 30, 2013.

This language was to be amended to Senate Bill No. 501 during the implementer session, but the Senate chose not to take it up. The Department had sought to change an effective date to S. 411 which had been enacted into law. When the Legislative Commissioner's Office (LCO) drafted the amendment to do so, they mistakenly chose language from the file copy of S. 411, rather than the public act language. Once LCO recognized that they used the wrong language, a new amendment was drafted (LCO #5818) which, again, was not taken up in the Senate. However, Senate leadership assured the Department that they would fix this issue early in 2013.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

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

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Yes, and all states have a similar or later filing deadline for the enterprise risk report.

(3) Have certain constituencies called for this action? The Insurance Association of Connecticut

(4) What would happen if this was not enacted in law this session? Carriers would be required to file an enterprise risk report with the Department by June 30th, 2013, and CT would be the only state with a different filing deadline.

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

If this is a resubmission, please share:

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* This language was to be amended to Senate Bill No. 501 during the implementer session, but the Senate chose not to take it up. The Department had sought to change an effective date to S. 411 which had been enacted into law. When the Legislative Commissioner's Office (LCO) drafted the amendment to do so, they mistakenly chose language from the file copy of S. 411, rather than the public act language. Once LCO recognized that they used the wrong language, a new amendment was drafted (LCO #5818) which, again, was not taken up in the Senate. However, Senate leadership assured the Department that they would fix this issue early in 2013.

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? No

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? Senate leadership, specifically Sen. Harp, assured us that they'd take this language up in the early part of the 2013 legislative session. The Insurance Association of CT also worked on the language for the enterprise risk report deadline.

(4) What was the last action taken during the past legislative session? The legislature enacted the language through the passage of S. 411, Public Act 12-103. Due to a drafting error by LCO during the implementer session, the language reverted back to an earlier version of the bill.

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
N/A

State N/A
Federal N/A
Additional notes on fiscal impact

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

Sec. 127. Section 38a-135 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2012*):

(a) Every insurance company **[**which**]** that is authorized to do business in this state and **[**which**]** is a member of an insurance holding company system shall register with the commissioner on a form prescribed by **[**him**]** the commissioner. Any insurance company **[**which**]** that is subject to registration under this section shall register **[**within**]** not later than fifteen days after it becomes subject to registration, and annually thereafter by June first of each year for the previous calendar year, unless the commissioner, for good cause shown, extends the time for registration, in which case it shall register within such extended time.

(b) (1) Every insurance company subject to registration shall file a registration statement **[**which**]** that shall contain the following current information:

[(1)**]** (A) The capital structure, general financial condition, ownership and management of the insurance company and any person controlling the insurance company;

[(2)**]** (B) The identity and relationship of every member of the insurance holding company system;

[(3)**]** (C) The following agreements in force, and transactions outstanding or **[**which**]** that have occurred during the last calendar year between such insurance company and its affiliates: (i) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurance company or of the insurance company by its affiliates; (ii) purchases, sales or exchanges of assets; (iii) transactions not in the ordinary course of business; (iv) guarantees or undertakings for the benefit of an affiliate **[**which**]** that result in an actual contingent exposure of the insurance company's assets to liability, other than insurance contracts entered into in the ordinary course of the insurance company's business; (v) management agreements, service contracts and cost-sharing arrangements; (vi) reinsurance agreements; (vii) dividends and other distributions to securityholders; and (viii) consolidated tax allocation agreements;

[(4)**]** (D) Any pledge of the insurance company's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system; **[**and**]**

(E) If requested by the commissioner, financial statements of or within an insurance holding company system, including all affiliates. Such statements may include, but are not limited to, annual audited financial statements filed with the Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended from time to time, or the Securities Exchange Act of 1934, as amended from time to time. An insurance company required to file financial statements under this subparagraph may provide the commissioner with its parent corporation's financial statements that are most recently filed with said commission;

(F) Statements that the insurance company's board of directors oversees corporate governance and internal controls of such company, and that such company's officers or senior management have approved, implemented and continue to maintain such governance and controls;

[(5)**]** (G) Other matters concerning transactions between registered insurance companies and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner; and

(H) Any other information required by regulations adopted in accordance with the provisions of chapter 54.

[(c)**]** (2) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

[(d)**]** (c) No information need be disclosed on the registration statement filed pursuant to subsection (b) of this section if such information is not material for the purposes of

this section. Unless the commissioner by regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees involving one-half of one per cent or less of the insurance company's admitted assets as of the thirty-first day of December next preceding shall not be deemed material for purposes of this section.

[(e)**]** (d) Subject to subsection (b) of section 38a-136, each registered insurance company shall report to the commissioner all dividends and other distributions to securityholders **[**within**]** not later than fifteen business days **[**following**]** after the declaration thereof or such other period as the commissioner shall prescribe by regulation.

[(f)**]** (e) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurance company, where such information is reasonably necessary to enable the insurance company to comply with the provisions of sections 38a-129 to 38a-140, inclusive.

(f) (1) The ultimate controlling person of each insurance company subject to registration under this section shall file an annual enterprise risk report in a form and manner prescribed by the commissioner. The initial report shall not be filed prior to June 1, 2013. The annual enterprise risk report shall identify, to the best of such person's knowledge and belief, the material risks within the insurance holding company system that could pose enterprise risk to the insurance company. The report shall be filed with the lead state commissioner as determined by the procedures in NAIC's applicable financial analysis handbook. Such report shall (A) be confidential by law and privileged, (B) not be subject to disclosure under section 1-210, (C) not be subject to subpoena, and (D) not be subject to discovery or admissible in any civil action. The commissioner shall not make such report public without the prior written consent of the ultimate controlling person that filed such report unless the commissioner, after giving the ultimate controlling person and the insurance company to which such report pertains and its affiliates within the insurance holding company system who would be affected thereby notice and opportunity to be heard, determines that the interests of policyholders, securityholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part thereof in such manner as the commissioner may deem appropriate. The commissioner may use such report in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(2) The commissioner may share the enterprise risk report only with the insurance regulatory official of another state with laws or regulations substantially similar to subsection (a) of section 38a-137 and who has agreed, in writing, to maintain the confidentiality and privileged status of such report.

(g) The commissioner shall terminate the registration of any insurance company **[**which**]** that demonstrates that it no longer is a member of an insurance holding company system.

(h) The commissioner may require or allow two or more affiliated insurance companies subject to registration hereunder to file a consolidated registration statement.

(i) The commissioner may allow an insurance company **[**which**]** that is authorized to do business in this state and **[**which**]** is part of an insurance holding company system to register on behalf of any affiliated insurer **[**which**]** that is required to register under subsection (a) of this section and to file all information and materials required to be filed under this section.

(j) Any person may file with the commissioner a disclaimer of affiliation with any insurance company and any insurance company may file a disclaimer of affiliation with any other person. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurance company as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurance company shall be relieved of any duty to register or report under this section **[**which**]** that may arise out of the insurance company's relationship with such person unless **[**and until**]** the commissioner disallows such disclaimer. The commissioner shall disallow such disclaimer only after furnishing all parties in interest with notice and an opportunity to be heard, and after making specific findings of fact to support such disallowance.

(k) The failure to file a registration statement or any amendment, **[**or**]** addition thereto or summary or an enterprise risk report required by this section within the time specified for such filing shall be a violation of sections 38a-129 to 38a-140, inclusive.

(l) The commissioner may by regulation or order exempt any insurance company or class of insurance companies from registration under this section if, in **[**his**]** the commissioner's judgment, registration by such company or class of companies is not necessary to effectuate the purposes of said sections.

(m) A foreign or alien insurer shall not be required to register pursuant to this section if it is (1) subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile **[**which**]** that are substantially similar to those contained in this section and subsections (a), (b), (f) and (g) of section 38a-136 or **[**if it is**]** (2) admitted in the domiciliary jurisdiction of the principal insurer in its holding company system and in said jurisdiction is subject to disclosure requirements and standards adopted by statute or regulation **[**which**]** that are substantially similar to those contained in this section and subsections (a), (b), (f) and (g) of section 38a-136. The commissioner may require any authorized insurer **[**which**]** that is a member of a holding company system **[**which is**]** not subject to registration under this section to

furnish a copy of the registration statement or other information filed by such insurance company with the insurance regulatory authority of its domicile or the domicile of the principal insurer in its holding company system, as the case may be.

(n) (1) To assess the business strategy, financial, legal or regulatory position risk exposure, risk management or governance processes of a domestic insurance company registered under this section that is part of an insurance holding company system that has international operations, and as part of the examination pursuant to section 38a-14a of such insurance company, the commissioner may initiate, be a member of or participate in a supervisory college, which shall be a temporary or permanent forum for communication between and cooperation among state, federal and international regulatory officials.

(2) If the commissioner initiates a supervisory college, the commissioner shall (A) establish the membership of, and participation by state, federal or international regulatory officials in, such supervisory college, (B) establish the functions of the supervisory college and the role of members and participants, and select a chairperson for such supervisory college, (C) coordinate the activities of the supervisory college, including meeting planning and processes for information sharing that comply with the applicable confidentiality provisions set forth in section 38a-137, and (D) establish a crisis management plan for such supervisory college.

(3) The commissioner may enter into written agreements with state, federal or international regulatory officials for the governing of the activities of a supervisory college. Any such agreements shall maintain the confidentiality requirements under section 38a-137.

(4) Each insurance company subject to registration under this section shall be assessed for and shall pay to the commissioner its share of the reasonable costs, including reasonable travel expenses, of the commissioner's participation in a supervisory college. Such payment shall be in addition to any other taxes, fees and moneys otherwise payable to the state. The commissioner shall establish the assessment method for such costs and provide reasonable notice to each insurance company subject to any such assessment.

(5) Nothing in this subsection shall be construed to limit the authority of the commissioner to regulate an insurance company or its affiliate under the commissioner's jurisdiction or to delegate any regulatory authority of the commissioner to a supervisory college. "

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Consumer Protection Enhancements

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

STATE AGENCY:
INSURANCE DEPARTMENT

LIAISON: DEBRA KORTA
PHONE: 860-297-3864
E-MAIL: DEBRA J. KORTA

LEAD AGENCY DIVISION REQUESTING THIS PROPOSAL:
CONSUMER AFFAIRS

AGENCY ANALYST/DRAFTER OF PROPOSAL:
TIM LYONS

Title of Proposal
An Act to Promote Consumer Protection Enhancements to Life and Health Insurance

Statutory Reference
CONN. GEN. STAT. sections 38a-436 and 38-816 amendments and new proposal

Proposal Summary
The purpose of this proposal is to: (1) require life insurers to retain proof of delivery or mailing of the policy to their individual policyholders, (2) grant the Insurance Commissioner the authority to order an insurance producer to pay restitution, (3) require health insurers to pay interest on disability income and long term care insurance claims which are not paid on a timely basis, (4) assure that health insurance benefits are contractually guaranteed, and to avoid any possible conflict of interest that may occur when the health carrier responsible for providing benefits has discretionary authority to decide what benefits are due.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

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

(6) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?*
Some other states have prohibited discretionary clauses.

(7) *Have certain constituencies called for this action?*
NO

(8) *What would happen if this was not enacted in law this session?*
The Insurance Department will be denied an opportunity to provide greater protections to consumers.

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

If this is a resubmission, please share: (Not Applicable)

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

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

(7) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

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

PROPOSAL IMPACT

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

Agency Name: No other agency impacted
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

No Fiscal Impact

State
No Fiscal Impact

Federal
No Fiscal Impact

Additional notes on fiscal impact

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

AN ACT TO PROMOTE CONSUMER PROTECTION ENHANCEMENTS TO LIFE AND HEALTH INSURANCE

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

Section 1. Section 38a-436 of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2014):

Every individual life insurance policy delivered or issued for delivery to any person in this state shall have printed thereon or attached thereto a notice stating, in substance, that the policy may be returned by the applicant for cancellation by delivering or mailing the policy to the insurer or to the insurance agent through whom it was effected, at any time within ten days after receipt of the policy by the applicant, and that upon the delivery or mailing the policy shall be void ab initio. The insurer shall maintain proof of the date and manner of delivery or mailing of the policy and notice, to be made available to the commissioner upon request, for a period of seven years after delivery of the policy. Such proof may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any other process that accurately demonstrates the date of delivery or mailing of the policy and notice.

Section 2. Sec. 38a-702k. Denial, nonrenewal or revocation of producers license. Hearings. Penalties. (Effective January 1, 2014):

(a) The commissioner may place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or may levy a civil penalty in accordance with the provisions of this title, or may take any combination of such actions, for any one or more of the following causes: (1) Providing incorrect, misleading, incomplete or materially untrue information in the license application; (2) violating any insurance laws, or violating any regulation, subpoena or order of the commissioner or of another state's commissioner; (3) obtaining or attempting to obtain a license through misrepresentation or fraud; (4) improperly withholding, misappropriating or converting any moneys or properties received in the course of doing an insurance business; (5) intentionally misrepresenting the terms of an actual or proposed insurance contract or

application for insurance; (6) having been convicted of a felony; (7) having admitted or been found to have committed any insurance unfair trade practice or fraud; (8) using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere; (9) having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory; (10) forging another's name to an application for insurance or to any document related to an insurance transaction; (11) improperly using notes or any other reference material to complete an examination for an insurance license; (12) knowingly accepting insurance business from an individual who is not licensed; (13) failing to comply with an administrative or court order imposing a child support obligation; or (14) failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(b) If the action by the commissioner is to nonrenew a license or to deny an application for a license, the commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the commissioner, not later than thirty days after the notice, for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held not later than twenty days after receipt of such request and shall be held pursuant to section 38a-19.

(c) The license of a business entity may be suspended, revoked or refused if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the commissioner nor corrective action taken.

(d) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine pursuant to section 38a-774.

(e) The commissioner shall retain the authority to enforce the provisions of, and impose any penalty or remedy authorized by, this title against any person who is under investigation for or charged with a violation of this title even if the person's license or registration has been surrendered or has lapsed by operation of law.

(f) The commissioner may order a licensee to make restitution if the commissioner finds that the licensee has committed a violation described in: subdivisions (4), (7), or (8) of subsection (a) of this section.

Section 3. Section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (effective January 1, 2014):

The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; (b) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (f) is a misrepresentation, including, but not limited to, an intentional misquote of a premium rate, for the purpose of inducing or tending to induce to the purchase, lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (h) misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of, any oral or written statement or any pamphlet, circular, article or literature which is false or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or

tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive; or making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following: (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (b) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; (c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; (d) refusing to pay claims without conducting a reasonable investigation based upon all available information; (e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; (f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; (g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; (h) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; (i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured; (j) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; (k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; (l) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; (m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to

influence settlements under other portions of the insurance policy coverage; (n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; (o) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy.

(7) Failure to maintain complaint handling procedures. Failure of any person to maintain complete record of all the complaints which it has received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this subsection "complaint" shall mean any written communication primarily expressing a grievance.

(8) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money or other benefit from any insurer, producer or individual.

(9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following practices shall be considered discrimination within the meaning of section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-825: (a) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (b) in the case of policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; (c) readjustment of the rate of premium for a group insurance policy based on loss or expense experience, or both, at the end of the first or any subsequent policy year, which may be made retroactive for such policy year.

(10) Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in this state, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit any unfair discrimination against particular individuals or persons so

licensed.

(11) Favored agent or insurer: Coercion of debtors. (a) No person may (i) require, as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or producer or group of producers; (ii) unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien; (iii) require directly or indirectly that any borrower, mortgagor, purchaser, insurer or producer pay a separate charge, in connection with the handling of any insurance policy required as security for a loan on real estate or pay a separate charge to substitute the insurance policy of one insurer for that of another; or (iv) use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagee, vendor or lender, or is to the detriment of the borrower, mortgagor, purchaser, insurer or the producer complying with such a requirement. (b)(i) Subsection (a)(iii) does not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of subsection (a)(ii), such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required. (iii) The commissioner may investigate the affairs of any person to whom this subsection applies to determine whether such person has violated this subsection. If a violation of this subsection is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of section 38a-815, subsections (b) and (e) of section 38a-817 and this section. (iv) For purposes of this section, "person" includes any individual, corporation, limited liability company, association, partnership or other legal entity.

(12) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of physical disability, mental or nervous condition as set forth in section 38a-488a or mental retardation, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(13) Refusing to insure, refusing to continue to insure or limiting the amount, extent or

kind of coverage available to an individual or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. For purposes of this subdivision, "refusal to insure" includes the denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured is blind or partially blind, except that an insurer may exclude from coverage any disability, consisting solely of blindness or partial blindness, when such condition existed at the time the policy was issued. Any individual who is blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons with respect to all other conditions, including the underlying cause of the blindness or partial blindness.

(14) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of exposure to diethylstilbestrol through the female parent.

(15) (A) Failure by an insurer, or any other entity responsible for providing payment to a health care provider or a claimant pursuant to an insurance policy, to pay accident and health claims, including, but not limited to, claims for payment or reimbursement to health care providers or a claimant, within the time periods set forth in subparagraph (B) of this subdivision, unless the Insurance Commissioner determines that a legitimate dispute exists as to coverage, liability or damages or that the claimant has fraudulently caused or contributed to the loss. Any insurer, or any other entity responsible for providing payment to a health care provider or a claimant pursuant to an insurance policy, who fails to pay such a claim or request within the time periods set forth in subparagraph (B) of this subdivision shall pay the claimant or health care provider the amount of such claim plus interest at the rate of fifteen per cent per annum, in addition to any other penalties which may be imposed pursuant to sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due a claimant or health care provider pursuant to this section is less than one dollar, the insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center.

(B) Each insurer or other entity responsible for providing payment to a health care provider or a claimant pursuant to an insurance policy subject to this section, shall pay claims not later than:

(i) For claims filed in paper format, sixty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim[,] submitted by a health care provider as determined in accordance with section 38a-477, or a deficiency in the information submitted by a claimant in accordance with the insurer's practices and procedures, as reasonably applied to the claimant, the insurer shall (I) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the information requested; and

(ii) For claims filed in electronic format, twenty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim[,] submitted by a health care provider as determined in accordance with section 38a-477, or a deficiency in the information submitted by a claimant in accordance with the insurer's practices and procedures, as reasonably applied to the claimant, the insurer shall (I) notify the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than ten days after the insurer receives a claim for payment or reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than ten days after the insurer receives the information requested.

(C) As used in this subdivision, "health care provider" means a person licensed to provide health care services under chapter 368d, chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

(16) Failure to pay, as part of any claim for a damaged motor vehicle under any automobile insurance policy where the vehicle has been declared to be a constructive total loss, an amount equal to the sum of (A) the settlement amount on such vehicle plus, whenever the insurer takes title to such vehicle, (B) an amount determined by multiplying such settlement amount by a percentage equivalent to the current sales tax rate established in section 12-408. For purposes of this subdivision, "constructive total loss" means the cost to repair or salvage damaged property, or the cost to both repair and salvage such property, equals or exceeds the total value of the property at the time of the loss.

(17) Any violation of section 42-260, by an extended warranty provider subject to the provisions of said section, including, but not limited to: (A) Failure to include all statements required in subsections (c) and (f) of section 42-260 in an issued extended warranty; (B) offering an extended warranty without being (i) insured under an adequate extended warranty reimbursement insurance policy or (ii) able to demonstrate that reserves for claims contained in the provider's financial statements are not in excess of one-half the provider's audited net worth; (C) failure to submit a copy of an issued extended warranty form or a copy of such provider's extended warranty reimbursement policy form to the Insurance Commissioner.

(18) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because such individual has been a victim of family violence.

(19) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of genetic information. Genetic information indicating a predisposition to a disease or condition shall not be deemed a preexisting condition in the absence of a diagnosis of such disease or condition that is based on other medical information. An insurance company, hospital service corporation, health care center or fraternal benefit society providing individual health coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be prohibited from refusing to insure or applying a preexisting condition limitation, to the extent permitted by law, to an individual who has been diagnosed with a disease or condition based on medical information other than genetic information and has exhibited symptoms of such disease or condition. For the purposes of this subsection, "genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

(20) Any violation of sections 38a-465 to 38a-465q, inclusive.

(21) With respect to a managed care organization, as defined in section 38a-478, failing to establish a confidentiality procedure for medical record information, as required by section 38a-999.

(22) Any violation of sections 38a-591d to 38a-591f, inclusive.

Section 4. (NEW) (Effective January 1, 2014):

(a). As used in subsection (b), the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

1. "Commissioner" shall have the meaning assigned to it by section 38-1;
2. "Health carrier" shall have the meaning assigned to it by section 38a-591a;
3. "Health insurance" shall have the meaning assigned to it by be section 38a-469;
4. "Person" shall have the meaning assigned to it by section, 38a-1.

(b) No policy, contract, certificate or agreement offered or issued in this state by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health insurance may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

(c) A violation of subsection (b) shall be subject to a penalty as described in section.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Spending Cap

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

State Agency: Connecticut Insurance Department

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: Commissioner's office

Agency Analyst/Drafter of Proposal:
Jon Arsenault

Title of Proposal
An Act Exempting the Insurance Department from the Spending Cap

Statutory Reference 2-33a

Proposal Summary

This proposal would exempt the Insurance Department from the Spending Cap. The Insurance Department is funded wholly from assessments on the domestic insurance industry and receives no general fund monies. Removing the Department from the spending cap will enable the administration to use those monies for other funding purposes.

Through a variety of fees and other revenue sources, the Department generates close to $100 million that is sent directly to the general fund. Yet, when spending cuts are mandated, the Insurance Department is required to adhere to those cuts despite not receiving any general fund dollars.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

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

(10) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Unaware of other state practices.

(11) Have certain constituencies called for this action? Sen. Crisco has introduced a similar proposal in previous legislative sessions.

(12) What would happen if this was not enacted in law this session? The Insurance Department's budget would continue to fall under the state's spending cap.

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

If this is a resubmission, please share:

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

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

(11) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

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

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) N/A

State
The Department's budget will no longer be included as an expenditure for purposes of the spending cap.

Federal
N/A

Additional notes on fiscal impact

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

Sec. 2-33a. Limitation on expenditures authorized by General Assembly. The General Assembly shall not authorize an increase in general budget expenditures for any fiscal year above the amount of general budget expenditures authorized for the previous fiscal year by a percentage which exceeds the greater of the percentage increase in personal income or the percentage increase in inflation, unless the Governor declares an emergency or the existence of extraordinary circumstances and at least three-fifths of the members of each house of the General Assembly vote to exceed such limit for the purposes of such emergency or extraordinary circumstances. Any such declaration shall specify the nature of such emergency or circumstances and may provide that such proposed additional expenditures shall not be considered general budget expenditures for the current fiscal year for the purposes of determining general budget expenditures for the ensuing fiscal year and any act of the General Assembly authorizing such expenditures may contain such provision. As used in this section, "increase in personal income" means the average of the annual increase in personal income in the state for each of the preceding five years, according to United States Bureau of Economic Analysis data; "increase in inflation" means the increase in the consumer price index for urban consumers during the preceding twelve-month period, according to United States Bureau of Labor Statistics data; and "general budget expenditures" means expenditures from appropriated funds authorized by public or special act of the General Assembly, provided (1) general budget expenditures shall not include expenditures for payment of the principal of and interest on bonds, notes or other evidences of indebtedness, expenditures pursuant to section 4-30a, **expenditures of the Insurance Fund established pursuant to section 38a-52a,** or current or increased expenditures for statutory grants to distressed municipalities, provided such grants are in effect on July 1, 1991, and (2) expenditures for the implementation of federal mandates or court orders shall not be considered general budget expenditures for the first fiscal year in which such expenditures are authorized, but shall be considered general budget expenditures for such year for the purposes of determining general budget expenditures for the ensuing fiscal year. As used in this section, "federal mandates" means those programs or services in which the state must participate, or in which the state participated on July 1, 1991, and in which the state must meet federal entitlement and eligibility criteria in order to receive federal reimbursement, provided expenditures for program or service components which are optional under federal law or regulation shall be considered general budget expenditures.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Technical Revisions

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

State Agency:
Connecticut Insurance Department

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: Various

Agency Analyst/Drafter of Proposal: Various

Title of Proposal
An Act Concerning Revisions to the Insurance Statutes

Statutory Reference Various

Proposal Summary

Sec 1. Amend 38a-8(d) to allow the Commissioner to share/receive confidential information with the Federal Insurance Office, which was created under the Dodd-Frank Act, and the Bank for International Settlements, an international organization which fosters international monetary and financial cooperation and serves as a bank for central banks.

Sec. 2. Amend the financial examination statute (38a-14) to include a provision requiring that the Board of Directors of examined companies receive and review exam reports and provide documentation of such review for their corporate files which are subject to audit and review by the Department

Sec. 3. Amend 38a-53 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations

Sec. 4. Amends subsection (5)section 38a-91bb, to specifically reference the definition of personal risk insurance which is also defined in 38a-663 and harmonize it with the definition of commercial risk insurance provided for in these same two sections, 38a-91bb and 38a-663.

Sec. 5 & 6. Amend 38a-162 and 38a-163 to increase license fees for Premium Finance Companies – brings this license fee into parity with general business corporation licenses in CT.

Sec. 7. Amend 38a-188 to extend exam authority to health care centers.

Sec. 8. Amend subsection (e) of section 38a-363, to reference the proper section of Connecticut General Statute, section 14-1.

Sec. 9. Amend 38a-614 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements for fraternal societies when the domiciliary regulator has waived such filings or approved filing delays in defined situations; raise late fees to same level as for insurers and health care centers.

Sec. 10 & 11. To clarify the obligations of an insurer when the insurer is also acting as a third-party administrator.

Sec. 12. Amends 38a-741 to change the submission date and format of surplus lines affidavit filings. Requires surplus lines companies to file electronically on a quarterly basis.

Sect. 13. To clarify that policies providing benefits pursuant to Medicare Parts C or D are not covered by the Connecticut Life and Health Insurance Guaranty Association Act.

Sec. 14. Changes the timing of when the funds held in "surety bail bond agents examination account" established by P.A. 11-45 can be transferred to the General Fund so the Insurance Department is allowed the use of the funds for a full year, rather than 5 months allowed by the law as enacted.

Sec. 15. Repeal 38a-477b(b)

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(13) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(14) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(15) Have certain constituencies called for this action?
(16) What would happen if this was not enacted in law this session?

Sec. 1. Enhances the Department's ability to share and receive information with the Federal Insurance Office and handle international data calls/requests by working with international organizations and ensuring confidentiality of data.

Sec. 2. Amend the financial examination statute (38a-14) to include a provision requiring that the Board of Directors of examined companies receive and review exam reports and provide documentation of such review for their corporate files which are subject to audit and review by the Department – to engage the governing body of a company that has been examined.

Sec. 3. Amend 38a-53 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations – to provide for the Commissioner to use his discretion to waive late fees when the insurance regulator of the domicile state of foreign insurers has waived or approved a delay for filing requirements; increase late fees for fraternals on par with insurers and health care centers.

Sect. 4. To harmonize the references in the captive insurance law to the statutory provisions defining personal risk insurance and commercial risk insurance. Connecticut statutes authorize captive insurers to apply to the Insurance Commissioner for a license to do the business of insurance against any kind of loss, damage or liability properly a subject of insurance, including commercial risk insurance, as defined in section 38a-663. However, certain specific limitations are provided for in the same section. Subsection (5) prohibits writing personal risk insurance for motor vehicles and homeowners.

Sec. 5 & 6. Amend 38a-162 and 38a-163 to increase license fees for Premium Finance Companies – brings this license fee into parity with general business corporation licenses in CT.

Sec. 7. Amend 38a-188 to extend exam authority to health care centers – codifies the explicit authority to examine these companies.

Sect. 8. To update the reference in the definition of private passenger motor vehicle regarding commercial registration to match the current statutory reference found in the motor vehicle statute, section 14-1.

Sec. 9. Amend 38a-614 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations – to provide for the Commissioner to use his discretion to waive late fees when the insurance regulator of the domicile state of foreign insurers has waived or approved a delay for filing requirements; increase late fees for fraternals on par with insurers and health care centers.

Sect. 10 & 11. To clarify the obligations of an insurer when such insurer is also acting as a third-party administrator.

Sec. 12. Current process is inefficient and time-consuming. Changing to electronic and quarterly submission of documents will eliminate unnecessary paper and provide for a more streamlined and efficient process.

Sect. 13. To conform to the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Guaranty Association Model Act and requested by the Board of Directors of the Connecticut Insurance Guaranty Association.

Sec. 14. The current timing allows for the use of the funds for only 5 months each year while the Department needs to access the funds for the whole year to pay for audits. Current law limits the ability to fully utilize the funds collected for their intended purpose and hampers the Department's ability to meet mandated responsibilities.

Sec. 15. Repeal 38a-477b(b) – as a result of the Patient Protection and Affordable Care Act, rescissions are now subject to external review and our amended external review law reflects that requirement. This provision which requires the Insurance Commissioner to approve all rescissions which conflicts with the federal requirements and should be repealed to avoid confusion and conflict.

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

If this is a resubmission, please share:

(13) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package? Other Insurance Department proposals were higher priorities and time ran out during session.

(14) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? No

(15) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(16) What was the last action taken during the past legislative session? Passed the House, died on the Senate Calendar.

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

State

Insignificant – State may receive some additional revenue because of increased fees, but these should not be significant; we currently license 40 premium finance companies which will provide an additional annual revenue gain of $10,000 through the increased fee.

Federal

Additional notes on fiscal impact

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

Sec 1. This will reduce the time and resources expended by the Department by enhancing the Department's ability to handle international data calls/requests by explicating working with international organizations and ensuring confidentiality of the data.

Sec. 2. Amend the financial examination statute (38a-14) to include a provision requiring that the Board of Directors of examined companies receive and review exam reports and provide documentation of such review for their corporate files which are subject to audit and review by the Department – requires Financial Regulation to distribute the report to the examined company's Board members

Sec. 3. Amend 38a-53 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations – permits waiver under defined conditions; increase fraternal late fee on par with insurers and health care centers

Sect. 4. Amends subsection (5)section 38a-91bb, to specifically reference the definition of personal risk insurance which is also defined in 38a-663 and harmonize it with the definition of commercial risk insurance provided for in these same two sections, 38a-91bb and 38a-663.

Sec. 5 & 6. Amend 38a-162 to increase license fees for Premium Finance Companies – insignificant revenue gain.

Sec. 7. Amend 38a-188 to extend exam authority to health care centers – already performing exams; this codifies the explicit authority.

Sect. 8. To update the reference in the definition of private passenger motor vehicle regarding commercial registration to match the current statutory reference found in the motor vehicle statute, section 14-1.

Sec. 9. Amend 38a-614 to provide the Commissioner discretion to waive a late filing fees for quarterly and annual financial statements when the domiciliary regulator has waived such filings or approved filing delays in defined situations – to provide for the Commissioner to use his discretion to waive late fees when the insurance regulator of the domicile state of foreign insurers has waived or approved a delay for filing requirements; increase late fees for fraternals on par with insurers and health care centers.

Sect. 10 & 11. To clarify the obligations of an insurer when such insurer is also acting as a third-party administrator.

Sect. 12. Eliminates an unnecessary and time-consuming paper filing requirement by replacing it with a quarterly electronic submission.

Sect. 13. To conform to the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Guaranty Association Model Act and requested by the Board of Directors of the Connecticut Insurance Guaranty Association.

Sec 14. This ensures that the Department has the necessary funds throughout the year, as intended by the Act.

Sec. 15. Repeal 38a-477b(b) – eliminates need for Legal staff to review rescission applications (with the enactment of sections 54-66 of Public Act No. 11-58, Legal staff has already ceased performing these reviews) This will codify Bulletin HC-85.

AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.

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

Section 1. Subsection (d) of section 38a-8 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective upon passage)*:

(d) The commissioner shall develop a program of periodic review to ensure compliance by the Insurance Department with the minimum standards established by the National Association of Insurance Commissioners for effective financial surveillance and regulation of insurance companies operating in this state. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, pertaining to the financial surveillance and solvency regulation of insurance companies and health care centers as are reasonable and necessary to obtain or maintain the accreditation of the Insurance Department by the National Association of Insurance Commissioners. The commissioner shall maintain, as confidential, any confidential documents or information received from the National Association of Insurance Commissioners, the Federal Insurance Office, [or] the International Association of Insurance Supervisors or the Bank for International Settlements, or any documents or information received from state or federal insurance, banking or securities regulators or similar regulators in a foreign country which are confidential in such jurisdictions. The commissioner may share any information, including confidential information, with the National Association of Insurance Commissioners, the Federal Insurance Office, the International Association of Insurance Supervisors the Bank for International Settlements, or state or federal insurance, banking or securities regulators or similar regulators in a foreign country so long as the commissioner determines that such entities agree to maintain the same level of confidentiality in their jurisdiction as is available in this state. The commissioner may engage the services of, at the expense of a domestic, alien or foreign insurer, attorneys, actuaries, accountants and other experts not otherwise part of the commissioner's staff as may be necessary to assist the commissioner in the financial analysis of the insurer, the review of the insurer's license applications, and the review of transactions within a holding company system involving an insurer domiciled in this state. No duties of a person employed by the Insurance Department on November 1, 2002, shall be performed by such attorney, actuary, accountant or expert.
ed to the Governor upon its completion.

Section 2. Subsection (g) of section 38a-14 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(g) A copy of the final examination report, or a summary thereof approved by the commissioner, together with the recommendations or statements of the commissioner or the examiner, shall be presented by the insurance company or health care center's chief executive

officer to the insurance company or health care center's board of directors or similar governing body at a meeting thereof which shall be held within 90 days following receipt of the report in final form by the insurance company or health care center. A copy of the report shall also be furnished by the secretary of the insurance company or health care center to each member of the insurance company or health care center's board of directors. The secretary of the insurance company or health care center shall certify in writing that a copy of the examination report has been so furnished and such certificate shall be deemed to constitute knowledge of the contents of the report by each such member. The commissioner may, if he deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

Section 3. Subsection (e) of section 38a-53 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) Any insurance company or health care center doing business in this state which fails to file any report or statement required under this section shall pay a late filing fee of one hundred seventy-five dollars per day for each day from the due date of such report or statement to the date of filing. The commissioner, in his discretion, may waive a late filing fee if (1) reports or statements cannot be filed because the governor of the domicile state of the insurance company or health care center doing business in this state has formally declared an emergency state, as prescribed under the laws of that state, which impairs the ability to file the reports or statements, or (2) reports or statements cannot be filed because the insurance regulator of the domicile state of the insurance company or health care center doing business in this state has permitted the domiciliary filings to be submitted late.

Section 4. Subsection (5) of 38a-91bb of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2013)*:

(5) No captive insurance company may provide personal risk insurance, as defined in section 38a-663, for private passenger motor vehicle or homeowners insurance coverage or any component thereof;

Section 5. Subsection (b) of section 38a-162 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(b) All licenses issued under the provisions of sections 38a-160 to 38a-170, inclusive, shall expire on the thirtieth day of June following the date of their issuance. At the time of application for an insurance premium finance company license and for every annual renewal thereof there shall be paid to the commissioner the sum of **[**fifty**]** three hundred dollars. If a license is not issued the fee shall be returned.

Section 6. Subsection (a) of section 38a-163 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a)Each applicant for an insurance premium finance company license or for any renewal of such license shall file with the commissioner a written application in such manner and form as the commissioner shall prescribe together with said fee of **[**fifty**]** three hundred dollars which fee shall be returned to the applicant if such license is not granted.

Section 7. Subsection (a) of section 38a-188 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

Each health care center governed by sections 38a-175 to 38a-192, inclusive, shall be exempt from the provisions of the general statutes relating to insurance in the conduct of its operations under said sections and in such other activities as do constitute the business of insurance, unless expressly included therein, and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51, 38a-52, 38a-56, 38a-57, 38a-129 to 38a-140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a health care center shall not be deemed in violation of sections 38a-815 to 38a-819, inclusive, solely by virtue of such center selectively contracting with certain providers in one or more specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-777, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, provided a health care center organized as a nonprofit, nonstock corporation shall be exempt from sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, 38a-769, 38a-770, 38a-772 to 38a-777, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health care center is operated as a line of business, the foregoing provisions shall, where possible, be applied only to that line of business and not to the organization as a whole. The commissioner may adopt regulations, in accordance with chapter 54, stating the circumstances under which the resources of a person which controls a health care center, or operates a health care center as a line of business will be considered in evaluating the financial condition of a health care center. Such regulations, if adopted, shall require as a condition to the consideration of the resources of such person which controls a health care center, or operates a health care center as a line of business to provide satisfactory assurances to the commissioner that such person will assume the financial obligations of the health care center. During the period prior to the effective date of regulations issued under this section, the commissioner shall, upon request, consider the resources of a person which controls a health care center, or operates a health care center as a line of business, if the commissioner receives satisfactory assurances from such person that it will assume the financial obligations of the health care center and determines that such person meets such other requirements as the commissioner determines are necessary. A health care center organized as a nonprofit, nonstock corporation shall be exempt from the sales and use tax and all property of each such corporation shall be exempt from state, district and municipal taxes. Each corporation governed by sections 38a-175 to 38a-192, inclusive, shall be subject to the provisions of sections 38a-903 to 38a-961, inclusive. Nothing in this section shall be construed

to override contractual and delivery system arrangements governing a health care center's provider relationships.

Section 8: Subsection (e) of 38a-363 of the general statutes is repealed and the following is substituted in lieu thereof *(Effective October 1, 2013)*:

(e) "Private passenger motor vehicle" means a: (1) Private passenger type automobile; (2) station-wagon-type automobile; (3) camper-type motor vehicle; (4) high-mileage-type motor vehicle as defined in section 14-1; (5) truck-type motor vehicle with a load capacity of fifteen hundred pounds or less, registered as a passenger motor vehicle, as defined in [said section] section 14-1, or as a passenger and commercial motor vehicle, as defined in [said section] section 14-1, or used for farming purposes; or (6) a vehicle with a commercial registration as defined in [subdivision (12) of said section] section 14-1. It does not include a motorcycle or motor vehicle used as a public or livery conveyance.

Section 9. Subsection (8) of section 38a-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(8) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred seventy-five dollars for each day during which such neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this state shall cease while such default continues. The commissioner, in his discretion, may waive a late filing fee if (1) reports or statements cannot be filed because the governor of the domicile state of the society doing business in this state has formally declared an emergency state, as prescribed under the laws of that state, which impairs the ability to file the reports or statements, or (2) reports or statements cannot be filed because the insurance regulator of the domicile state of the society doing business in this state has permitted the domiciliary filings to be submitted late.

Section 10. 38a-720 of the general statutes is repealed and the following is substituted in lieu thereof: *(Effective Upon Passage)*

Definitions. As used in sections 38a-720 to 38a-720n, inclusive:

(1) "Adjuster" means an independent or contracted individual who investigates or settles loss claims. "Adjuster" does not include an employee of an insurer who investigates or settles claims incurred under insurance contracts written by the insurer or an affiliated insurer.

(2) "Affiliate" or "affiliated" has the same meaning as provided in section 38a-1.

(3) "Business entity" means a corporation, a limited liability company or any other similar form of business organization, whether for profit or nonprofit.

(4) "Commissioner" means the Insurance Commissioner.

(5) "Control" or "controlled by" has the same meaning as provided in section 38a-1.

(6) "Insurance producer" has the same meaning as provided in section 38a-702a.

(7) "Insurer" or "insurance company" means any person or combination of persons doing any kind or form of insurance business other than a fraternal benefit society, and includes a captive insurance company, as defined in section 38a-91aa, a captive insurer, as defined in section 38a-91k, a licensed insurance company, a medical service corporation, a hospital service corporation, a health care center, and a consumer dental plan that provides employee welfare benefits on a self-funded basis or as defined in section 38a-577.

(8) "NAIC" means the National Association of Insurance Commissioners.

(9) "Person" has the same meaning as provided in section 38a-1.

(10) "Sell" means the exchange of an insurance contract for money or other consideration, by any means, on behalf of an insurance company.

(11) "Third-party administrator" means any person who directly or indirectly underwrites, collects premiums or charges from, or adjusts or settles claims on, residents of this state in connection with life, annuity or health coverage [offered or provided by an insurer]. "Third-party administrator" does not include:

(A) An employer administering its employee benefit plan or the benefit plan of an affiliated employer under common management and control;

(B) A union administering a benefit plan on behalf of its members;

(C) An insurer that is licensed in this state or is acting as an authorized insurer with respect to insurance lawfully issued to cover a Connecticut resident, and sales representatives thereof;

(D) An insurance producer who is licensed to sell life, annuity or health coverage in this state, whose activities are limited exclusively to the sale of insurance;

(E) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(F) A trust and its trustees, agents and employees acting pursuant to such trust established in conformity with 29 USC Section 186, as amended from time to time;

(G) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, and its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents and employees acting pursuant to a custodian account that meets the requirements of Section 401(f) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(H) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent such credit union, financial institution or mortgage lender collects or remits premiums to licensed insurance producers or limited lines producers or to authorized insurers, in connection with loan payments;

(I) A credit card issuing company that advances or collects premiums or charges from its credit cardholders who have authorized collection;

(J) An attorney-at-law who adjusts or settles claims in the normal course of such attorney's practice or employment and who does not collect premiums or charges in connection with life, annuity or health coverage;

(K) An adjuster who is licensed in this state or is not subject to the licensure requirements of chapter 702 and whose activities are limited to adjusting claims;

(L) An insurance producer who is licensed in this state and acting as a managing general agent, as defined in section 38a-90a, whose activities are limited exclusively to those specified in said section;

(M) A business entity that is affiliated with an insurer licensed in this state and that undertakes activities as a third-party administrator only for the direct and assumed insurance business of the affiliated insurer;

(N) A consortium of federally qualified health centers funded by the state, providing services only to the recipients of programs administered by the Department of Social Services;

(O) A pharmacy benefits manager registered under section 38a-479bbb;

(P) An entity providing administrative services to the Health Reinsurance Association established under section 38a-556; or

(Q) A nonprofit association or one of its direct subsidiaries that provides access to insurance as part of the benefits or services such association or subsidiary makes available to its members.

(12) "Underwrites" or "underwriting" means the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer or self-funded plan, and the overall planning and coordination of a benefits program.

(13) "Uniform application" means the current version of the National Association of Insurance Commissioners' Uniform Application for Third-Party Administrators.

Section 11. 38a-720a of the general statutes is repealed and the following is substituted in lieu thereof: *(Effective Upon Passage)*

License. Exemptions. Written agreement required. (a) No person shall offer to act as or hold himself out to be a third-party administrator in this state unless such person is licensed pursuant to section 38a-720j, or is exempt from licensure pursuant to subsection (b) of this section. This requirement shall not apply to a person employed by a third-party administrator to the extent that such person's activities are under the supervision and control of the third-party administrator. The authority granted to a third-party administrator pursuant to sections 38a-720 to 38a-720i, inclusive, shall not exempt such third-party administrator's employees from the licensing requirements of chapters 701b and 702.

(b) (1) Any insurer licensed in this state that also acts as a Third-party administrator as defined in section 38a-720 [directly or indirectly underwrites, collects premiums or charges from, or adjusts or settles claims for other than its policyholders, subscribers and certificate holders] shall be exempt from sections 38a-720b to 38a-720n, inclusive, provided such activities extend only to life, annuity or health coverages [only involve the lines of insurance] for which such entity [insurer] is licensed as an insurer in this state. Any such entity [insurer] shall (A) be subject to the provisions of chapter 704, (B) respond to all complaint inquiries received from the Insurance Department, not later than ten calendar days after the date a complaint is received by the insurer, and (C) with respect to any advertising that mentions any customer, obtain such customer's prior written consent.

(2) Nothing in this section shall authorize the commissioner to regulate a self-insured health plan subject to the Employee Retirement Income Security Act of 1974. The commissioner is authorized to regulate those activities an insurer acting as a third-party administrator undertakes for the administration of a self-insured health plan that do not relate to the health benefit plan and that comport with the commissioner's statutory authority to regulate insurance and the business of insurance as provided for in 29 USC 1144, as amended from time to time.

(c) No third-party administrator shall act as such without a written agreement between such third-party administrator and an insurer or other person utilizing the services of the third-party administrator, which shall be retained as part of the official records of both the third-party administrator and such insurer or other person for the duration of such agreement and for five years thereafter. The agreement shall contain all provisions required by this section, except insofar as those provisions that do not apply to the activities performed by the third-party administrator.

(d) The written agreement set forth in subsection (c) of this section shall include, but not be limited to:

(1) A statement of activities that the third-party administrator shall undertake on behalf of the insurer or other person utilizing the services of the third-party administrator, and the lines,

classes or types of insurance such third-party administrator is authorized to administer;

(2) A statement of the activities and responsibilities of the third-party administrator regarding the administration of or any standards pertaining to business underwritten by the insurer, benefits, premium rates, underwriting criteria or claims payment;

(3) A provision requiring the third-party administrator to render an accounting, on such frequency as the parties agree, that details all transactions performed by the third-party administrator pertaining to the business underwritten by the insurer or the business of the person utilizing the services of the third-party administrator;

(4) The procedures for any withdrawals to be made by the third-party administrator from the fiduciary account established under section 38a-720f. Such procedures shall address, but not be limited to: (A) Remittance to an insurer or other person utilizing the services of the third-party administrator who is entitled to remittance, (B) deposit in an account maintained in the name of the insurer or other person utilizing the services of the third-party administrator, (C) transfer to and deposit in a claims-paying account, with claims to be paid as provided for in subsection (d) of section 38a-720f, (D) payment to a group policyholder for remittance to the insurer or other person utilizing the services of the third-party administrator entitled to such remittance, (E) payment to the third-party administrator for its commissions, fees or charges, and (F) remittance of return premiums to the person or persons entitled to such return premiums;

(5) Procedures and requirements for the disclosures required to be made by the third-party administrator under section 38a-720h; and

(6) A termination provision, by which either party to the written agreement may terminate such agreement for cause, that includes a procedure to resolve any disputes regarding the cause for termination of such agreement.

(e) A third-party administrator or insurer or other person utilizing the services of the third-party administrator may, with written notice, terminate the written agreement for cause as provided in such written agreement. The insurer may suspend the underwriting authority of the third-party administrator during the pendency of any dispute regarding the cause for termination of the written agreement. The insurer or other person utilizing the services of the third-party administrator shall fulfill any legal obligations with respect to policies or plans affected by the written agreement, regardless of any dispute between the third-party administrator and the insurer or other person utilizing the services of the third-party administrator.

Section 12. Section 38a-741 is repealed and the following is substituted in lieu thereof:
(Effective upon passage)

Sec. 38a-741. (Formerly Sec. 38-81). Affidavit as to attempt to procure insurance from authorized insurers. (a) The commissioner shall maintain on a current basis a list of those lines of insurance or their components for which coverages are believed by the commissioner to be generally unavailable from licensed insurers. The commissioner shall republish the list and make it available to all licensees every six months. Any person may request in writing that the commissioner add or remove a line of insurance or its component from the current list at the next publication of the list. The commissioner's determinations of lines of insurance or their components to be added to or removed from the list shall not be subject to chapter 54 provided prior to making determinations, the commissioner shall provide opportunity for comments from interested persons.

(b) When any policy of insurance is procured under the authority of such license providing a line of insurance or its component which does not, on the effective date of coverage, appear on the current published list, there shall be executed, both by the licensee and by the insured, affidavits setting forth facts showing that such insured and such licensee were unable after diligent effort to procure, from any authorized insurer or insurers, the full amount of insurance required to protect the interest of such insured, and further showing that the amount of insurance procured from an unauthorized insurer or insurers is only the excess over the amount so procurable from authorized insurers. Such affidavits shall be filed in electronic format by such licensee with the commissioner [within forty-five days after such policies have been procured]on February first, May first, August first and November first of each year.

Section 13. Subsection (f) of section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to the persons specified in subsections (a) to (d), inclusive, of this section for direct, nongroup life, health or annuity policies or contracts and supplemental contracts to such policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by said sections. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(2) [Said sections] Sections 38a-858 to 38a-875, inclusive, shall not provide coverage for: (A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder; (B) any policy or contract of reinsurance, unless assumption certificates have been issued; (C) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value (i) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under

sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier; and (ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available; (D) a portion of a policy or contract issued to any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under (i) a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended from time to time; (ii) a minimum premium group insurance plan; or (iii) an administrative services only contract; (E) any stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan or another person obligated to pay life, health or annuity benefits; (F) any portion of a policy or contract to the extent that it provides dividends, experience rating credits, voting rights or provides that any fees or allowances be paid to any person, including, but not limited to, the policy or contract holder, in connection with the service to or administration of such policy or contract; (G) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; (H) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan; (I) any portion of an unallocated annuity contract that is not issued to, or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; (J) any subscriber contract issued by a health care center; (K) a contractual agreement that establishes the insurer's obligation by reference to a portfolio of assets that is not owned or possessed by the insurance company; (L) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to: (i) A claim based on marketing materials; (ii) a claim based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements; (iii) a misrepresentation of or regarding policy benefits; (iv) an extra-contractual claim; or (v) a claim for penalties or consequential or incidental damages; (M) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; [and] (N) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the

use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture; and (O) a policy or contract providing any hospital, medical, prescription drugs or other health care benefits pursuant to Part C or Part D of Subchapter XVIII of 42 USC 7, as amended from time to time, commonly known as Medicare Parts C and D, or any regulations issued pursuant thereto.

Section 14. Subsection (k) of section 1 of Public Act 11-45, as amended by Public Act 11-152, is repealed and the following is substituted in lieu thereof: *(Effective from passage)*

(k) (1) To further the enforcement of this section and sections 3 to 14, inclusive, of this act, and to determine the eligibility of any licensee, the commissioner may, as often as the commissioner deems necessary, examine the books and records of any such licensee. Each person licensed as a surety bail bond agent in this state shall, on or before January thirty-first, annually, pay to the commissioner a fee of four hundred fifty dollars to cover the cost of examinations under this subsection.

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

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

Section 15. Subsection (b) of section 38a-477b of the general statutes is repealed. (*Effective from passage*)

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Standard Valuation Law

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

State Agency: Connecticut Insurance Department

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Lead agency division requesting this proposal:
Actuarial Division

Agency Analyst/Drafter of Proposal:
Mark Franklin

Title of Proposal
An Act Concerning the Standard Valuation Law

Statutory Reference 38a-78

Proposal Summary

The amendments make changes to the Standard Valuation Law, 38a-78, to enable Principles Based Reserving (PBR) of life insurance companies' actuarial liabilities. This is an important and dynamic process to replace the current strictly formulaic approach at valuing life insurance reserves, which the Department and NAIC membership believes is overly static and in need of modernization. PBR uses risk analysis techniques such as modeling and simulation to better capture and evaluate various risks inherent in modern life insurance products. Elements of the modification include:

- The requirements for PBR. PBR will have the impact of allowing reserves to be established at truer level, reflecting company-specific and product-specific actuarial data.
- Requirements for life insurance companies to submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the Valuation Manual to facilitate regulatory review.
- Confidentiality provisions similar in principle to strict confidentiality provisions protecting sensitive financial and actuarial data provided to the Department to allow uninhibited access to this data so that reserves, and ultimately solvency, can be effectively monitored.
- Use of a Valuation Manual, which has recently been substantially completed by the NAIC. The Manual is intended to be dynamic to consider rapid changes in the marketplace, much as the NAIC Accounting and Procedures Manual, which sets out the details of Statutory Accounting, works now.
- Procedures for a vetting and approval process for future changes to the Valuation Manual, to include a supermajority approval of NAIC membership and approval of the Connecticut Insurance Commissioner.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(17) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? There have been no direct changes in federal, state and local laws affecting the legislation. However, there was a change in the National Association of Insurance Commissioners' (NAIC) model in 2009 setting forth these changes and the NAIC Standard Valuation Manual, which is key to these revisions, is expected to be completed this autumn.

(18) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? This bill is a modernization of the existing Standard Valuation Law which has been adopted in every state (including CT) plus DC and Puerto Rico. Every state legislature is meeting in 2013 (including several that will not meeing in 2014), but it is too early to quantify how many will take up the SVL revisions.

(19) Have certain constituencies called for this action? By revising the model in a vote of all member jurisdictions, the NAIC has called for this action, and the life and annuity industry (through the American Council of Life Insurers) expressed unqualified support on an August 18, 2012, conference call of the NAIC Life Insurance and Annuities Committee.

(20) What would happen if this was not enacted in law this session? If this is not enacted this session, we will introduce it again next session. As noted above, this bill has the support of both regulators and the industry. It is the product of a multi-year process that has considered industry concerns that modernization of the current law is needed to address the evolution of products to meet consumer interests, along with regulatory concerns for maintaining policyholder protections.

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

If this is a resubmission, please share:

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

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

(19) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

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

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) N/A
State N/A
Federal **N/A**
Additional notes on fiscal impact

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

The revisions to the Standard Valuation Law will authorize implementation of Principal Based Reserving (PBR), which is a more dynamic system of valuation than what is currently used, for policies issued after its effective date. The system that is being replaced is a formulaic approach, which is somewhat rigid and which can result in reserves being overstated or understated for particular companies and products. The Department, and the consensus of NAIC membership, is that the PBR approach will provide a more accurate or "right sized" valuation of a life insurer's policyholder liabilities.

STANDARD VALUATION LAW

(a)(1) This Act shall be known as the Standard Valuation Law.

(2) For the purposes of this Act the following definitions shall apply on or after the operative date of the valuation manual:

(A) The term "accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic

loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(B) The term "appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (c) of this Act.

(C) The term "company" means an entity, which (i) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this State and has at least one such policy in force or on claim or (ii) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this State.

(D) The term "deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(E) The term "life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(F) The term "NAIC" means the National Association of Insurance Commissioners.

(G) The term "policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this Act including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of

mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(H) The term "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (p) of this Act as specified in the valuation manual.

(I) The term "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(J) The term "tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(K) The term "valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this Act or as subsequently amended.

[(a)] (b) (1) The commissioner shall annually value, or cause to be valued, the reserve liabilities[,] (hereinafter called reserves)[,] for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state issued on or after January 1, 1981 and prior to the operative date of the valuation manual [,except that in the case of an alien company, the valuation shall be limited to its United States business, and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest, and methods, including net level premium method or other, used in the calculation of such reserves]. In calculating such reserves, [he] the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves [herein] required of any foreign or alien company, [he] the commissioner may accept [any] a valuation made, or

caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard [herein] provided in this Act. **[**and if the official of such state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.**]**

(2)The provisions set forth in sections (i), (j), (k), (l), (m), (n), (o), (p), and (q) of this act shall apply to all policies and contracts, as appropriate, subject to this act issued on or after January 1, 1981 and prior to the date of the valuation manual, and the provisions set forth in sections (r) and (s) shall not apply to any such policies and contracts.

(3) The minimum standard for the valuation of policies and contracts issued prior to January 1, 1981 shall be that provided by the laws in effect immediately prior to that date.

(4) For policies and contracts issued on or after the operative date of the valuation manual, the commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this act.

(5) The provisions set forth in subsections (r) and (s) of this act shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

[(b)(1) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1991.

(3) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(4) The opinion shall be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the commissioner may by regulation prescribe.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(6) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in regulations the commissioner may prescribe.

(7) Except in cases of fraud or wilful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(8) Disciplinary action by the commissioner against the company or the qualified actuary shall be as defined in such regulations by the commissioner.

(9) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(10) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(11) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, shall be kept confidential by the commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by regulations adopted under this section provided the memorandum or other material may otherwise be released by the commissioner (A) with the written consent of the company or (B) upon the request of the American Academy of Actuaries stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is referred to by the company in its marketing or is referred to before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall no longer be confidential.

(12) Any regulation adopted by the commissioner under the provisions of this subsection shall be adopted in accordance with the provisions of chapter 54.]

[(c)(1) Every life insurance company, except as exempted by or pursuant to regulation, shall annually include in the opinion required by subdivision (1) of subsection (b) of this section, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(2) The commissioner may provide by regulation for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this section.]

(c.) For Actuarial Opinions prior to the operate date of the valuation manual,

(1) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the

commissioner by regulation are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner shall define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope.

(2) Every life insurance company , except as exempted by regulation , shall also annually include in the opinion required by subsection (1) of this section, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(3) The commissioner may provide by regulation for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this section.

(d) Each opinion required by subsection (c)(2) shall be governed by the following provisions:

(1) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the

expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(e) Every opinion required by subsection (c) shall be governed by the following provisions:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1991.

(2) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(3) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by regulation prescribe.

(4) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(5) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in the regulation.

(6) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(7) Except as provided in subsections (12), (13) and (14); documents, materials or other information in the possession or control of the Department of Insurance that are a memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, shall be confidential by law and privileged, shall not be subject to sections 1-200 et seq. of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(8) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (8).

(9) In order to assist in the performance of the commissioner's duties, the commissioner:

(A) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (8) with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(B) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(C) May enter into agreements governing sharing and use of information consistent with subsections (8), (9) and (10).

(10) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the comissioner under this section or as a result of sharing as authorized in subsection (10).

(11) A memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section or by regulations promulgated hereunder.

(12) The memorandum or other material may otherwise be released by the commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material.

(13) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a governmental

agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(f) For actuarial opinions of reserves after the operative date of the valuation manual,

(1) Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(2) Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this State and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by subsection (1) of this section, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(g) Each opinion required by subsection (f) shall be governed by the following provisions:

(1) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the commissioner, shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(h) Every opinion subject to subsections (f) and (g) shall be governed by the following provisions:

(1) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(2) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(3) The opinion shall apply to all policies and contracts subject to subsection (f)(2), plus other actuarial liabilities as may be specified in the valuation manual.

(4) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(5) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of

another State if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this State.

(6) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

[(d)] (i) Except as otherwise provided in subsections [(e), (f) and (l)] (j), (k) and (q) of this section, the minimum standard for the valuation of all such policies and contracts issued prior to the effective date specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, shall be that provided by the laws in effect immediately prior to such date, except that the minimum standard for the valuation of annuities and pure endowments purchased prior to January 1, 1973, under group annuity and pure endowment contracts shall be the 1971 Group Annuity Mortality Table, or any modification of this table approved by the commissioner, and an interest rate of five per cent per annum. Except as otherwise provided in subsections [(e), (f) and (l)] (j), (k) and (q) of this section, the minimum standard for the valuation of all such policies and contracts issued on and after such effective date shall be the commissioner's reserve valuation methods defined in subsections [(g), (h) and (j)] (l), (m), (o) and (q) of this section, three and one-half percent (3 ½%) interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after {effective date of 1972 amendements to SVL}, four per cent (4%) interest for policies issued prior to such effective date five and one-half per cent (5 1/2%) interest for single premium life insurance policies and four and one-half per cent (4 ½%) interest for all other such policies and contracts issued on or after such effective date, and the following tables: (1) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners' 1958 Standard Ordinary Mortality Table for such policies issued prior to the compliance date established by subdivision (11) of subsection (e) of section 38a-439, provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than six years younger than the actual age of the insured and for such policies issued on or after the compliance date

established by subdivision (11) of subsection (e) of section 38a-439, (A) the Commissioners' 1980 Standard Ordinary Mortality Table, or (B) at the election of the company for any one or more specified plans of life insurance, the Commissioners' 1980 Standard Ordinary Mortality Table with ten-year select mortality factors, or (C) on or after January 1, 2005, until January 1, 2009, at the election of the company for any one or more specified plans of life insurance issued on or after January 1, 2004, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, except that with respect to such plans issued before April 1, 2005, such mortality table shall be used solely for the basis of valuation and nonforfeiture and shall not be used to increase the previously agreed required premium, or (D) issued on or after January 1, 2009, the Commissioners' 2001 Standard Ordinary Mortality Table, or (E) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies; (2) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners' 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies; (3) for total and permanent disability benefits in or supplementary to ordinary policies or contracts, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies. These tables shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies; (4) for accidental death benefits in or supplementary to policies, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies. These tables shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and (5) for group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the commissioner.

[(e)] (j) Except as otherwise provided in subsection [(f)] (k) of this section, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the effective date as specified in accordance with the provisions of subsection (h)

of section 38-130e of the general statutes, revision of 1958, revised to 1981, and for all annuities and pure endowments purchased on or after such effective date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation methods defined in subsections [(g) and (h)] (l) and (m) of this section and the following tables and interest rates: (1) For individual single premium immediate annuity contracts issued on or after such effective date, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and seven and one-half per cent interest; (2) for individual annuity and pure endowment contracts issued on or after such effective date, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such contract, or any modification of these tables approved by the commissioner, and five and one-half per cent interest for single premium deferred annuity and pure endowment contracts and four and one-half per cent interest for all other such annuity and pure endowment contracts; (3) for all annuities and pure endowments purchased on or after such effective date under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half per cent interest.

[(f)] (k) (1) The interest rates used in determining the minimum standard for the valuation of (A) all life insurance policies issued in a particular calendar year, on or after the compliance date established by subdivision (11) of subsection (e) of section 38a-439, (B) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982, (C) all annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts, and (D) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in this subsection;

(2) The calendar year statutory valuation interest rates, I, shall be determined as

follows and the results rounded to the nearest one-quarter of one per cent:

(A) For life insurance,

$$I = .03 + W (R_1 - .03) + \frac{W}{2} (R_2 - .09);$$

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W(R - .03),$$

Where R_1 is the lesser of R and .09,
R_2 is the greater of R and .09,
R is the reference interest rate defined in subdivision (4) of this subsection and
W is the weighting factor defined in subdivision (3) of this subsection.

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (B), the formula for life insurance stated in subparagraph (A) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subparagraph (B) shall apply to annuities and guaranteed interest contracts with guarantee durations of ten years or less.

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subparagraph (B) shall apply.

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (B) shall apply.

(F) If the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this subdivision differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one- half of one per cent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the foregoing, the calendar year statutory valuation interest rate for life insurance policies issued in a

calendar year shall be determined for 1980 using the reference interest rate defined for 1979 and shall be determined for each subsequent calendar year regardless of the compliance date established by subdivision (11) of subsection (e) of section 38a-439;

(3) The weighting factors referred to in the formulas stated in subdivision (2) of this subsection are given in the following tables:

(A) Weighting Factors For Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph (B), shall be as specified in tables (i), (ii) and (iii) according to the rules and definitions in (iv), (v) and (vi):

(i) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor For Plan Type		
	A	B	C

5 or less	.80	.60	.50
More than 5, not more than 10	.75	.60	.50
More than 10, not more than 20	.65	.50	.45
More than 20	.45	.35	.35

(ii) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (i) increased by:

	Plan Type		
	A	B	C
	.15	.25	.05

(iii) For annuities and guaranteed interest contracts valued on an issue guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in (i) or derived in (ii) increased by:

	Plan Type		
	A	B	C
	.05	.05	.05

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(v) Plan type as used in the tables in subparagraph (C) is defined as follows:

a. Plan Type A: At any time policyholder may withdraw funds only: (1) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

b. Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only: (1) With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of the interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

c. Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either: (1) Without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(vi) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract. The change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in fund;

(4) The reference interest rate referred to in subdivision (2) of this subsection shall be defined as follows: a. For all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; b. for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or year of purchase of Moody's Corporate Bond Yield

Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; c. for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in b. above, with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; d. for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in b. above, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; e. for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; f. for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in b. above, the average over a period of twelve months, ending on June thirtieth of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(5) In the event that Moody's Corporate Bond Yield Average-Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54, may be substituted.

[(g)] **(l)** Except as otherwise provided in subsections [(h), (j) and (l)] (m), (o) and (q) of this section, reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (1) over (2), as

follows: (1) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy, and (2) a net one year term premium for such benefits provided for in the first policy year provided that for any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (j) of this section, be the greater of the reserve as of such policy anniversary calculated as described in this subsection and the reserve as of such policy anniversary calculated as described in this subsection but with the value defined in subdivision (1) of this subsection being reduced by fifteen per cent of the amount of such excess first year premium, all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, the policy being assumed to mature on such date as an endowment, and the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in subsections (e) and (f) of this section shall be used. Reserves according to the commissioners reserve valuation method for: (A) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; (B) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; (C) disability and accidental death benefits in all policies and contracts; and (D) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this subsection.

[)] (m) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of

deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended. Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

[(i)] (n) (1) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the effective date as specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections [(f), (g), (i) and (k)] (l), (m), (o) and (p) of this section, and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies; (2) in no event shall the aggregate reserves for all policies, contracts and benefits be less than the aggregate reserves determined by the [qualified] appointed actuary to be necessary to render the opinion required by subsection [(b)] (d) of this section; (3) reserves for any category of policies, contracts or benefits as established by the commissioner may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein; (4) any such company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided; provided, for the purposes of this subsection, the holding of additional reserves previously determined by [a qualified] the appointed actuary to be necessary to render the opinion required by [subsection (b)] subsections (e) and (f) of this section shall not be deemed to be the adoption of a higher standard of valuation.

[(j)] (o) If in any contract year the gross premium charged by [any life insurance] a company on any policy or contract, in force as of or written after the effective date as specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the most recent minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum standards of mortality and rate of interest in effect in the year that the policy or contract was issued and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsections [(d) and (f)] (i) and (k) of this section. For any life insurance policy issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection [(g)] (l) of this section. The minimum reserve at each policy anniversary of such policy shall be the greater of the minimum reserve calculated in accordance with subsection [(g)] (l), of this section and the minimum reserve calculated in accordance with this subsection.

[(k)] (p) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such nature that the minimum reserves cannot be determined by the methods described in subsections [(g), (h), and (j)] (l), (m) and (o) of this section, the reserves which are held under any such plan must be appropriate in relation to the benefits and the pattern of premiums for that plan, and be computed by a method which is consistent with the principles of this standard valuation law, as determined by regulations adopted by the commissioner in accordance with the provisions of chapter 54.

(q) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (b)(4) and (5). For accident and health insurance contracts issued on or after January 1, 1981 and prior to the operative date of the

valuation manual the minimum standard of valuation is the standard adopted by the commissioner by regulation.

(r) (1)For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (b)(4) and (5), except as provided under subdivisions (5) and (7) of this subsection.

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(A) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths of the members voting, whichever is greater.

(B) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by States representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(C) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions: The fifty States of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when all of the following have occurred:

(A) The change to the valuation manual has been adopted by the NAIC by an affirmative vote representing at least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership, and

(B) Members of the NAIC representing jurisdictions totaling greater than 75% of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subdivision (3)(A) of this subsection: life, accident and health annual statements, health annual statements, or fraternal annual statements.

(4).. The valuation manual must specify all of the following:

(A) Minimum valuation standards for and definitions of the policies or contracts subject to subsections (b) (4) and (5). Such minimum valuation standards shall be:

(i) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to subection (b)(4) and (5);

(ii) The commissioners annuity reserve valuation method for annuity contracts subject to subsection (b) (2); and

(iii) Minimum reserves for all other policies or contracts subject to subsection (b)(4) and (5).

(B) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in subsection (s)(1) and the minimum valuation standards consistent with those requirements;

(C) For policies and contracts subject to a principle-based valuation under subsection (s):

(i) Requirements for the format of reports to the commissioner under subsection (s) (2) (B) and which shall include information necessary to determine if the valuation is appropriate and in compliance with this Act;

(ii) Assumptions shall be prescribed for risks over which the company does not have significant control or influence.

(iii) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

(D) For policies not subject to a principle-based valuation under Section (s) the minimum valuation standard shall either

(i) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(ii) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(E) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(F) The data and form of the data required under Section (q), with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(5.)In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this Act, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

(6). The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this Act. The commissioner may rely upon the opinion, regarding provisions contained within this Act, of a qualified actuary engaged by the commissioner of another State, district or territory of the United States. As used in this paragraph, term "engage" includes employment and contracting.

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this Act; and the company shall adjust the reserves as required by the commissioner.

(s)(1)A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(A) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(B) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while

recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(C) Incorporate assumptions that are derived in one of the following manners:

(i) The assumption is prescribed in the valuation manual.

(ii) For assumptions that are not prescribed, the assumptions shall:

(a) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(b) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(D) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

(A) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(B) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all

material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(C)Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(3). A principle-based valuation may include a prescribed formulaic reserve component.

(t) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(u)(1) For purposes of this subsection, "Confidential Information" shall mean:

(A) A memorandum in support of an opinion submitted under subsection (d) of this Act and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such memorandum;

B) All documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under subsection (r)(6) of this Act; provided, however, that if an examination report or other material prepared in connection with an examination made under sections 38a-14 and 38a-14a is not held as private and confidential information under the sections 38a-14 and 38a-14a, an examination report or other material prepared in connection with an examination made under subsection (r)(6) of this Act shall not be "Confidential Information" to the same extent as if such examination report or other material had been prepared under sections 38a-14- and 38a-14a;

(C) Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under subsection (s)(2)(B) of this Act evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such reports, documents, materials and other information;

(D) Any principle-based valuation report developed under subsection (s)(2)(C) of this Act and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such report; and

(E) Any documents, materials, data and other information submitted by a company under subsection (t) of this Act (collectively, "experience data") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the commissioner (together with any "experience data", the "experience materials") and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with such experience materials.

(2) Privilege for, and Confidentiality of, Confidential Information

(A) Except as provided in this subsection, a company's Confidential Information is confidential by law and privileged, and shall not be subject to section 1-200, et seq. of the General Statutes, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the commissioner is authorized to use the Confidential Information in the furtherance of any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(B) Neither the commissioner nor any person who received Confidential Information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any Confidential Information.

(C) In order to assist in the performance of the commissioner's duties, the commissioner may share Confidential Information (i) with other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries and (ii) in the case of Confidential Information specified in subsections (u)(1)(A) and (u)(1)(D) only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the Confidential Information is required for the purpose of professional disciplinary proceedings and with state, federal and international law enforcement officials; in the case of (i) and (ii), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the commissioner.

(D) The commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(E) The commissioner may enter into agreements governing sharing and use of information consistent with this subsection.

(F) No waiver of any applicable privilege or claim of confidentiality in the Confidential Information shall occur as a result of disclosure to the

commissioner under this section or as a result of sharing as authorized in subsection (u)(2)(C)).

(G) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection (2) shall be available and enforced in any proceeding in, and in any court of, this State.

(H) In this subsection, "regulatory agency," "law enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

(3) Notwithstanding subsection (2), any Confidential Information specified in subsections (1) (A) and (1) (D)):

(A) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsection (c) of this Act or principle-based valuation report developed under subsection (s) (2) (B) of this Act by reason of an action required by this Act or by regulations promulgated hereunder;

(B) May otherwise be released by the commissioner with the written consent of the company; and

(C) Once any portion of a memorandum in support of an opinion submitted under subsection (c) of this Act or a principle-based valuation report developed under subsection (s) (2) (B) of this Act is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

[(m)] (v) The provisions of sections 38a-77 and 38a-433 shall apply to policies issued by a company before the date of its election to comply with section 38-130e of the general statutes, revision of 1958, revised to 1981, or January 1, 1981, whichever occurred first. The provisions of section 38-130e of the general statutes, revision of 1958, revised to 1981, shall apply to policies issued by a company on and after the date of such election or on and after January 1, 1981, whichever occurred first, and before October 1, 1981.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_ORSA

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

State Agency:
Insurance Department

Liaison:Debra Korta
Phone:860.297.3864
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Lead agency division requesting this proposal:
Financial Regulation

Agency Analyst/Drafter of Proposal:
Beth Cook

Title of Proposal

AAC RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

Statutory Reference
New

Proposal Summary

To enact the NAIC RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT (ORSA) MODEL ACT. The ORSA Model will need to be in place no later than 1.1.15 for us to meet NAIC accreditation requirements. The ORSA Model is to provide requirements for maintaining a risk management framework and to provide guidance to insurers or insurance groups relating to filing ORSA summary reports to the Insurance Commissioner.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(21) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? NO
(22) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? In process
(23) Have certain constituencies called for this action? NAIC
(24) What would happen if this was not enacted in law this session? Could have next session

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

If this is a resubmission, please share:

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

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

(23) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

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

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
none

State
none

Federal

none

Additional notes on fiscal impact

none

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

Sec. 1 – Sets forth the purpose for the Act and the need to maintain this report as confidential
Sec. 2 – Identifies eff date of 1/1/15 and that this is applicable to all domestic insurers/insurance groups
Sec. 3 – Definitions
Sec. 4 – Requirement for n insurer tol maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks
Sec. 5 – Requirement to conduct an ORSA Report annually
Sec. 6 – Requirements for the ORSA Summary Report
Sec. 7 – Exemption from ORSA criteria
Sec. 8 – Requirement to use ORSA Guidance Manual to prepare ORSA Sumary Report
Sec. 9 – Confidentiality
Sec. 10 – Late filing penalties

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT

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

Section 1. (NEW) (*Effective January 1, 2015*) (a) The purpose of sections 1 through 10, inclusive, of this act is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment (ORSA) and provide guidance and instructions for filing an ORSA Summary Report with the insurance commissioner of this state.

(b) The requirements of sections 1 through 10, inclusive, of this act shall apply to all insurers domiciled in this state unless exempt pursuant to section 7.

(c) The Legislature finds and declares that the ORSA Summary Report will contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of this Legislature that the ORSA Summary Report shall be a confidential document filed with the commissioner, that the ORSA Summary Report will be shared only as stated herein and to assist the commissioner in the performance of his or her duties, and that in no event shall the ORSA Summary Report be subject to public disclosure.

Sec. 2. (NEW) (*Effective January 1, 2015*) (a) The requirements of sections 1 through 10, inclusive, of this act shall apply effective January 1, 2015 to all insurers domiciled in this state unless exempt pursuant to section 7 of this act. The first filing of the ORSA Summary Report shall be in 2015 pursuant to section 6 of this act.

Sec. 3. (NEW) (*Effective January 1, 2015*) As used in sections 1 through 10, inclusive, of this act:

(1) "Insurance group" means, for the purposes of this act, those insurers and affiliates included within an insurance holding company system as defined in sections 38a-129 through 38a-140, inclusive.
(2) "Insurer" has the same meaning as provided in section 38a-(1), except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.
(3) "NAIC" means the National Association of Insurance Commissioners
(4) "ORSA" means Own Risk and Solvency Assessment which is a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurer group's current business plan, and the sufficiency of capital resources to support those risks.

(5) “ORSA Guidance Manual” means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the NAIC and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NIAC.
(6) “ORSA Summary Report” means a confidential high-level summary of an insurer or insurance group’s ORSA.

Sec. 4. (NEW) (*Effective January 1, 2015*) An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Sec. 5. (NEW) (*Effective January 1, 2015*) Subject to section 8 of this act, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

Sec. 6. (NEW) (*Effective January 1, 2015*) (a) Upon the commissioner’s request, and no more than once each year, an insurer shall submit to the commissioner an ORSA Summary Report any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer and or the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the reports required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the NAIC.

(b) The reports shall include a signature of the insurer or insurance group’s chief risk officer or other executive having responsibility for the oversight of the insurer’s enterprise risk management process attesting to the best of his belief and knowledge that the insurer applied the enterprise risk management process described in the ORSA Report Summary Report and that a copy of the report has been provided to the insurer’s board of directors or the appropriate committee thereof.

(c) An insurer may comply with subsection (a) by providing the most recent and substantially similar reports provided by the insurer or another member of the insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator in a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

Sec. 7. (NEW) (*Effective January 1, 2015*)(a) An insurer shall be exempt from the requirements of sections 1 through 10, inclusive, of this act if (1) the insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $5000,000,000; and, (2) the insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international

direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(b) If an insurer qualifies for an exemption pursuant to paragraph (1) of subsection (a), but the insurance group of which the insurer is a member does not qualify for an exemption pursuant to paragraph (2) of subsection (a), then the ORSA Summary Report that may be required pursuant to section 4 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers provided any combination of reports includes every insurer within the insurance group.

(c) If an insurer does not qualify for exemption pursuant to paragraph (1) of subsection (a), but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (2) of subsection (a), then the only ORSA Summary Report that may be required pursuant to section (4) shall be the report applicable to that insurer.

(d) An insurer that does not qualify for an exemption pursuant to subsection (a) may apply to the commissioner for a waiver from the requirements of sections 1 through 10, inclusive, of this act based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(e) Notwithstanding the exemptions stated in this section,

(1) the commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report, based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests and international supervisory requests.

(2) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report if the insurer has Risk-Based Capital for company action level event as set forth in sections 38a-7-1 to 38a-71-13, inclusive and 38a-193-1 to 38a-193-13, inclusive, of the Regulations of Connecticut State Agencies, meets one or more of the standards of an insurer deemed to be in a hazardous financial condition as defined in sections 38a-8-101 to 38a-8-104, inclusive, of the Regulations of Connecticut State Agencies, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(f) If an insurer that qualifies for an exemption pursuant to subsection (a) subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one (1) year following the year the threshold is exceeded to comply with the requirements of sections 1 to 10, inclusive, of this act.

Sec. 8. (NEW) (*Effective January 1, 2015*)(a) The ORSA Summary Report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection (b) of

this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

(b) The review of the ORSA Summary Report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multi-state or global insurers and insurance groups.

Sec. 9. (NEW) (*Effective January 1, 2015*)(a) Documents, materials or other information, including the ORSA Summary Report, in the possession of or control of the Insurance Department that are obtained by, created by or disclosed to the commissioner or any other person under sections 1 to 10, inclusive, of this act, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

(b) Neither the commissioner nor any person who received documents, materials or other ORSA related information, through examination or otherwise, while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to sections 1 to 10, inclusive, of this act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the commissioner's regulatory duties, the commissioner

(1) may, upon request, share documents, materials or other ORSA related information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this section , including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in sections 38a-129 to 38a-140, with the NAIC and any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality; and,

(2) may receive documents, materials or other ORSA related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in sections 38a-129 to 38a-140, and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(3) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to sections 1 to 10, inclusive, of this act, consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third party consultant pursuant to sections 1 to 10, inclusive, of this act, including procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Specify that ownership of information shared with the NAIC or a third party consultant pursuant to sections 1 to 10, inclusive, of this act remains with the commissioner and the NAIC's or a third party consultant's use of the information is subject to the direction of the commissioner;

(iii) Prohibit the NAIC or third party consultant from storing the information shared pursuant to sections 1 to 10, inclusive, of this act in a permanent database after the underlying analysis is completed;

(iv) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third party consultant pursuant to sections 1 to 10, inclusive, of this act is subject to a request or subpoena to the NAIC or a third party consultant for disclosure or production;

(v) Require the NAIC or a third party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third party consultant pursuant to sections 1 to 10, inclusive, of this act;

(vi) In the case of an agreement involving a third party consultant, provide for the insurer's written consent.

(d) The sharing of information and documents by the commissioner pursuant to sections 1 to 10, inclusive, of this act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of sections 1 to 10, inclusive, of this act.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials or other ORSA related information shall occur as a result of disclosure of such ORSA related information or documents to the commissioner under this section or as a result of sharing as authorized in sections 1 to 10, inclusive, of this act.

(f) Documents, materials or other information in the possession or control of the NAIC or a third party consultant pursuant to sections 1 to 10, inclusive, of this act shall be confidential by law and privileged, shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

Sec. 10. (NEW) (*Effective January 1, 2015)* Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in sections 1 to 10, inclusive, of this act shall be required, after notice and hearing, to pay a penalty of $1000 for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Loss Ratio Guarantee

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

State Agency: Connecticut Insurance Department

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: Life and Health Division

Agency Analyst/Drafter of Proposal: Mary Ellen Breault

Title of Proposal: An Act Repealing the State Medical Loss Ratio Guarantee

Statutory Reference 38a-481

Proposal Summary Repeal the loss ratio guarantee and 30 day deemer in the individual health insurance rating law.

With the enactment of the Patient Protection and Affordable Care Act (PPACA) and the federal Medical Loss Ratio (MLR) rebate requirement, it is not appropriate to continue to permit companies to file a state loss ratio guarantee for an individual product that may be inconsistent with the federal MLR market rebate requirements.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(25) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? Yes, with the enactment of PPACA and the MLR rebate requirements, our state law is inconsistent and unnecessary.

(26) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Not aware.

(27) Have certain constituencies called for this action? The Office of the Healthcare Advocate

(28) What would happen if this was not enacted in law this session? Carriers may continue to file their form/rate filings under this provision of law that may be inconsistent with federal law.

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

If this is a resubmission, please share:

(25) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package? This was not a proposal that was introduced by the Insurance Department but the concept was included in a bill that was enacted but vetoed by the Governor (S. 11; PA 11-170). S. 11 was a highly controversial bill that, if enacted, would have required public rate hearings for health insurance rates requests. The language in this proposal to eliminate the loss ratio guarantee, was included within S. 11.

(26) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? We anticipate that the Office of the Healthcare Advocate (OHCA) and the Attorney General's office may also be filing a similar proposal in 2013.

(27) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? Insurers, health care advocates, OHCA, the Department, and Sen. Crisco

(28) What was the last action taken during the past legislative session? See notes above.

PROPOSAL IMPACT

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

Agency Name: Agency Contact (name, title, phone): Date Contacted: Approve of Proposal ___ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) N/A
State N/A
Federal N/A
Additional notes on fiscal impact

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

Sec. 38a-481. (a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. Rate filings must include an actuarial memorandum including but not limited to pricing assumptions and claims experience, premiums, and loss ratios from the inception of the policy. The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer which has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until [the expiration of thirty days after] it has been filed [or unless sooner] and approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

(c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(d) **[**Rates on a particular policy form will not be deemed excessive if the insurer has filed a loss ratio guarantee with the Insurance Commissioner which meets the requirements of subsection (e) of this section provided (1) the form of such loss ratio guarantee has been explicitly approved by the Insurance Commissioner, and (2) the current expected lifetime loss ratio is not more than five per cent less than the filed lifetime loss ratio as certified by an actuary. The insurer shall withdraw the policy form if the commissioner determines that the lifetime loss ratio will not be met. Rates also will not be deemed excessive if the insurer complies with the terms of the loss ratio guarantee. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to assure that the use of a loss ratio guarantee does not constitute an unfair practice.

(e) Premium rates shall be deemed approved upon filing with the Insurance Commissioner if the filing is accompanied by a loss ratio guarantee. The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and shall contain as a minimum the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(2) A guarantee that the actual Connecticut loss ratios for the experience period in which the new rates take effect and for each experience period thereafter until any new rates are filed will meet or exceed the loss ratios referred to in subdivision (1) of this subsection. If the annual earned premium volume in Connecticut under the particular policy form is less than one million dollars and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nation-wide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained;

(3) A guarantee that the actual Connecticut or nation-wide loss ratio results, as the case may be, for the experience period at issue will be independently audited by a certified public accountant or a member of the American Academy of Actuaries at the insurer's expense. The audit shall be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Insurance Commissioner not later than June thirtieth following the end of the experience period;

(4) A guarantee that affected Connecticut policyholders will be issued a proportional refund, which will be based on the premiums earned, of the amount necessary to bring the actual loss ratio up to the anticipated loss ratio referred to in subdivision (1) of this subsection. If nation-wide loss ratios are used, the total amount refunded in Connecticut shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned from all Connecticut policyholders who will receive refunds

and divided by the total premium earned in all states on the policy form. The refund shall be made to all Connecticut policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal two dollars or more. The refund shall include interest, at six per cent, from the end of the experience period until the date of payment. Payment shall be made during the third quarter of the year following the experience period for which a refund is determined to be due;

(5) A guarantee that refunds less than two dollars will be aggregated by the insurer. The insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center;

(6) A guarantee that the insurer, if directed by the Insurance Commissioner, shall withdraw the policy form and cease the issuance of new policies under the form in this state if the applicable loss ratio exceeds the durational target loss ratio for the experience period by more than twenty per cent, provided the calculations are based on at least two thousand policyholder-years of experience either in Connecticut or nation-wide**.]**

[(f)] For the purposes of this section:

(1) "Loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations; and

(2) "Experience period" means the calendar year for which a loss ratio guarantee is calculated.

[(g)] (e) Nothing in this chapter shall preclude the issuance of an individual health insurance policy which includes an optional life insurance rider, provided the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

[(h)] (f) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state shall: (1) Move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole; or (3) use an individual's history of taking a prescription drug for anxiety for six months or less as a factor in its underwriting unless such history arises directly from a medical diagnosis of an underlying condition.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
100112_CID_Service of Process

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

State Agency: INSURANCE DEPARTMENT

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: Market Conduct Division

Agency Analyst/Drafter of Proposal: Barbara Rezner

Title of Proposal
AN ACT CONCERNING SERVICE OF PROCESS ON THE INSURANCE COMMISSIONER

Statutory Reference
CONN. GEN STAT. §38a-25

Proposal Summary: Amend Connecticut's statutes to require foreign and alien insurers to have a resident registered agent for service of process.

Service of process for non-domestic insurers is made on the Insurance Commissioner. The Insurance Department maintains a registry used to forward the papers after service. The Department must look up the name and address for the insurer, make copies of the material, attach labels, create envelopes and a certificate of mailing. At a later point in time the certificate is returned and must be matched to the paperwork. The paperwork is placed in the state archives. The entire process is clerical in nature, does not involve activity by the Department, beyond the clerical functions outlined, and potentially delays delivery to the insurer by adding an additional party to the process.

Section 1. Amends section 38a-25 to require non-domestics to appoint a resident agent for service of process. It allows the Insurance Commissioner to be served when the insurer fails to make such an appointment, the appointed agent cannot, with reasonable diligence, be found or the company is no longer authorized to do business.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

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

(30) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Yes. At least 15 other states either permit or require service on a resident agent.

(31) Have certain constituencies called for this action? No.

(32) What would happen if this was not enacted in law this session? The current procedures would remain in place.

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

If this is a resubmission, please share:

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

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

(31) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? N/A

(32) What was the last action taken during the past legislative session? N/A

PROPOSAL IMPACT

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

Agency Name: No other agencies affected.
Agency Contact (name, title, phone): N/A
Date Contacted: N/A

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments
N/A

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) No fiscal impact.

State The state will realize an expense savings. Clerical time previously devoted to the processing can be redirected. The state will cease to incur the cost of certified mailings. Over a recent 4.5 month period there were 828 items sent via mail with return receipt requested. Return receipt costs $2.35 per item. The state will also cease to incur the copying and storage costs.

Federal No fiscal impact.

Additional notes on fiscal impact

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

AN ACT CONCERNING SERVICE OF PROCESS ON THE INSURANCE COMMISSIONER

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

Section 1. Section 38a-25 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) (1) Each foreign and alien insurer authorized to do business in this state shall appoint a person in this state as agent for service of process in any proceeding arising from or related to any transaction having a connection with this state.

(2) The Insurance Commissioner is an alien or foreign insurer's agent on whom process may be served if the:

(A) insurer fails to appoint or maintain an agent under subsection (a)(1) of this section;

(B) agent appointed under subsection (a)(1) of this section cannot with reasonable diligence be found; or

(C) the insurer's certificate of authority is revoked.

(b) The Insurance Commissioner is the agent for receipt of service of legal process on the following:

(1) In accordance with subsection (a)(2) of this section, foreign [Foreign] and alien insurance companies authorized to do business in this state in any proceeding arising from or related to any transaction having a connection with this state.

(2) Fraternal benefit societies authorized to do business in this state.

(3) Insurance-support organizations as defined in section 38a–976, transacting business outside this state which affects a resident of this state.

(4) Risk retention groups, as defined in section 38a–250.

(5) Purchasing groups designating the Insurance Commissioner as agent for receipt of service of process pursuant to section 38a–261.

(6) Eligible surplus lines insurers authorized by the commissioner to accept surplus lines insurance.

(7) Except as provided by section 38a–273, unauthorized insurers or other persons assisting unauthorized insurers who directly or indirectly do any of the acts of insurance business as set forth in subsection (a) of section 38a–271.

(8) The Connecticut Insurance Guaranty Association and the Connecticut Life and Health Insurance Guaranty Association.

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

(10) Nonresident insurance producers and nonresident surplus lines brokers licensed by the Insurance Commissioner.

(11) Life settlement providers and life settlement brokers licensed by the commissioner.

(12) Nonresident reinsurance intermediaries designating the commissioner as agent for receipt of service of process pursuant to section 38a–760b.

(13) Workers' compensation self-insurance groups, as defined in section 38a–1001.

(14) Persons alleged to have violated any provision of section 38a–130.

(15) (A) Captive insurers, as defined in section 38a–91k, and (B) captive insurance companies, as defined in section 38a–91aa, if a registered agent cannot be found with reasonable diligence at the registered office of a captive insurance company.

[(b)] (c) Each foreign and alien insurer by applying for and receiving a license to do insurance business in this state, each fraternal benefit society by applying for and receiving a certificate to solicit members and do business, each surplus lines insurer declared to be an eligible surplus lines insurer by the commissioner, each insurance-support organization transacting business outside this state that affects a resident of this state, and each unauthorized insurer by doing an act of insurance business prohibited by section 38a–272, shall be considered to have irrevocably appointed the Insurance Commissioner as agent for receipt of service of process in accordance with subsection [(a)] (b) of this section. Such appointment shall continue in force so long as any certificate of membership, policy or liability remains outstanding in this state.

[(c)] (d) The commissioner shall be the agent for the executors, administrators or personal representatives, receivers, trustees or other successors in interest of the persons specified under subsection [(a)] (b) of this section.

[(d)] (e) Any legal process that is served on the commissioner pursuant to this section shall be of the same legal force and validity as if served on the principal.

[(e)] (f) The right to effect service of process as provided under this section shall not limit the right to serve legal process in any other manner provided by law.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Annuity and Long-Term Care

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

State Agency: Connecticut Insurance Department

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: Life and Health division

Agency Analyst/Drafter of Proposal: Mary Ellen Breault

Title of Proposal
An Act Concerning Annuity Sales and Long-Term Care

Statutory Reference 38a-458

Proposal Summary
This proposal would allow a carrier to accelerate the value of an annuity which could be used to pay for one's long-term care expenses, without having to purchase a separate long-term care policy.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(33) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? No
(34) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Unaware.
(35) Have certain constituencies called for this action? Insurance Association of CT
(36) What would happen if this was not enacted in law this session? Carriers would be unable to sell products with this feature.

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

If this is a resubmission, please share:

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

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

(35) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

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

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

N/A

State
N/A

Federal
N/A

Additional notes on fiscal impact

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

Sec. 38a-458. (a) [On and after June 16, 1989, any] Any life insurance company doing business in this state may issue life insurance policies or certificates, or riders or endorsements thereto, [which] that provide, within the terms and conditions of the policy or certificate, long-term care benefits as described in section 38a-501 or 38a-528, provided such company is licensed for both life and health insurance in this state. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of this section. [Prior to the effective date of such regulations, any such policy, certificate, rider or endorsement may be filed with the commissioner and may be approved at the commissioner's discretion.]

(NEW) (b) Any life insurance company doing business in this state may issue an annuity policy or certificate, or rider or endorsement thereto that provides long-term care benefits that waive the surrender charges under the annuity policy or accelerate a specified portion of the annuity value of the annuity policy.

[(b)] (c) Long-term care benefits provided pursuant to subsection (a) or (b) of this section shall not be subject to the requirements of subsection (b) of section 38a-501 or subsection (b) of section 38a-528.

[(c)] (d) No insurance producer shall sell any such policy, certificate, rider or endorsement unless the producer is licensed to sell both life and health insurance in this state.

[(d)] (e) A life insurance policy or annuity with long-term care benefits issued pursuant to this section may include a rider that provides long-term care benefits that become payable upon exhaustion of [benefits] a specified amount of the death benefit under the life insurance policy or annuity value of the annuity policy. [The] Any elimination period limitations shall apply only to the acceleration phase of the life insurance or annuity policy to which the rider is attached. Such rider shall not contain an additional elimination period and may calculate the waiver of premium from the time benefits are payable under such rider.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Dispute Resolution

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

State Agency: Connecticut Insurance Department

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: Property and Casualty Division

Title of Proposal
An Act Concerning Catastrophe Dispute Resolution Mechanism

Statutory Reference New

Proposal Summary

This bill establishes a formal mechanism for the non-adversarial mediation of disputes between an insured homeowner and an insurer for the settlement of a claim arising under the homeowner's policy following a major catastrophe for which the Governor has declared a state of emergency. Mediation would be voluntary for insured claimants but mandatory for insurers. It would require that the amount in dispute be at least $500 or more.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(37) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? No
(38) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? RI
(39) Have certain constituencies called for this action? No
(40) What would happen if this was not enacted in law this session? Consumers would continue to utilize their rights under their homeowner's policy.

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

If this is a resubmission, please share:

(37) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package? Did not gain the support of members of the Insurance and Real Estate Committee.

(38) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? No

(39) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(40) What was the last action taken during the past legislative session? Introduced in 2008 and the Insurance and Real Estate Committee did not report it out.

(41)

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
N/A

State
N/A

Federal
N/A

Additional notes on fiscal impact

Insurers would pay the costs of conducting the mediation, including a nonrefundable fee specified by regulation, not to exceed $750. This fee is intended to cover the costs of administering this program, including the expected fee to be paid to a neutral qualified mediator.

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

Section 1. Section 38a-9 of the general statutes is repealed and the following is substituted in lieu thereof

(c) There is established within the Division of Consumer Affairs a program for the nonadversarial mediation of disputes between an insured and an insurer for the settlement of a claim arising under the insured's homeowner's insurance policy that involves loss due to a catastrophic event for which the Governor has declared a state of emergency. For purposes of this subsection, "claim" means any dispute arising from such circumstances or for which the insurer has denied payment, in which the difference between the position of the parties is five hundred dollars or more, notwithstanding any applicable deductible, except that the parties may agree to mediate a dispute involving a lesser amount. A claim does not include a dispute with respect to which the insurer has reported allegations of fraud, based on an investigation by the insurer's special investigative unit to the Insurance Department.

(1) The insurer shall bear all costs of conducting mediation, including, but not limited to, an administrative fee for the Insurance Department's or its designee's administration of this program and the mediator's fee. A nonrefundable payment for each mediation proceeding under this subsection shall be made to the Insurance Department, in an amount to be set by the Insurance Commissioner, pursuant to subparagraph (C) of subdivision (2) of this subsection.

(2) The Insurance Commissioner may adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of this subsection. Such regulations would include, but not be limited to, (A) the means and content of notification by the insurer to the insured of the right to mediation, (B) the forms and procedures to request mediation by the insured or the insurer, (C) the payment of mediation costs, which shall consist of a nonrefundable fee not to exceed seven hundred fifty dollars, (D) the requirements for insurers' participation at the mediation conference, (E) the scheduling of the mediation conference, (F) the conduct of the mediation conference, and (G) post-mediation reporting requirements, including the effect of any settlement agreement in the release of claims.

(3) If an insured chooses not to participate in the mediation program or if the parties are unsuccessful at resolving the claim, the insured may proceed under the appraisal process set forth in the insured's insurance policy, by litigation, or by any other dispute resolution procedure available under Connecticut law. If, as a result of mediation, it is determined that the only coverage applicable is provided under the National Flood Insurance Program, the administrative fee imposed by this section, as amended by this act, and paid by the insurer shall be refunded to the insurer or credited to the insurer's account with the Insurance Department or the Insurance Department's administrative designee of this program.

(4) Notwithstanding subsections (a) to (e), inclusive, of this section, the Insurance Commissioner may designate an entity or person as the administrator to carry out the responsibilities of this subsection.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Market Conduct Authority

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

State Agency: Connecticut Insurance Department

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: Market Conduct Division

Agency Analyst/Drafter of Proposal: Beth Cook

Title of Proposal
An Act Concerning Market Conduct Authority

Statutory Reference 38a-15

Proposal Summary

This amends 38a-15 (market conduct statute) to parallel the financial exam statute (38a-14) with respect to costs of exams, use of consultants paid by the regulated entity, payment for out of state travel by the examined entity, and work paper confidentiality.

Harmonizing the market conduct statute with the financial examination statute allows us to charge foreign and domestic insurance companies for the cost of consultants used as additional resources for the market conduct examination, and ensure that the work papers reviewing during those exams remain confidential.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

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

(42) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
Yes, most other states have similar language in their statute.

(43) Have certain constituencies called for this action?
No

(44) What would happen if this was not enacted in law this session?
We could not charge back the cost of consultants used in market conduct exams to the companies. This limits the number and frequency of resources available to conduct market conduct exams.

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

If this is a resubmission, please share:

(42) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
Proposal was part of a large technical revisions bill that has not passed in previous years, primarily due to time constraints and other competing priorities.

(43) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
No

(44) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
None

(45) What was the last action taken during the past legislative session?
Insurance and Real Estate Committee passed the bill on a vote of 18 to 2. Died on Senate Calendar.

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
N/A

State
N/A

Federal
N/A

Additional notes on fiscal impact

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

Sec. 5. Section 38a-15 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2011*):

(a) The commissioner shall, as often as **[**he**]** the commissioner deems it expedient undertake a market conduct examination of the affairs of any insurance company, health care center or fraternal benefit society doing business in this state.

(b) To carry out the examinations under this section, the commissioner may appoint, as market conduct examiners, one or more competent persons **[**, not officers or**]** who shall not be officers of, connected with or interested in any insurance company, health care center or fraternal benefit society, other than as a policyholder. In conducting the examination, the commissioner, **[**his**]** the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such an insurance company, health care center or fraternal benefit society and all persons deemed to have material information regarding the company's, center's or society's property or business. Each such company, center or society, its officers and agents, shall produce the books and papers, in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper **[**, in his**]** in such person's custody, deemed to be relevant to the examination, for the inspection of the commissioner, **[**his**]** the commissioner's actuary or examiners, when required. The officers and agents of the company, center or association shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so.

(c) Each market conduct examiner shall make a full and true report of each market conduct examination made by **[**him**]** such examiner, which shall comprise only facts appearing upon the books, papers, records or documents of the examined company, center or society or ascertained from the sworn testimony of its officers or agents or of other persons examined under oath concerning its affairs. The examiner's report shall be presumptive evidence of the facts therein stated in any action or proceeding in the name of the state against the company, center or society, its officers or agents. **[**The**]** Before filing such report, the commissioner shall grant a hearing to the company, center or society examined, **[**before filing any such report,**]** and may withhold any such report from public inspection for such time as **[**he**]** the commissioner deems proper. The commissioner may, if **[**he**]** said commissioner deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

[(d) All the expense of any examination made under the authority of this section, other than examinations of domestic insurance companies, shall be paid by the company, center or society examined, and domestic insurance companies and other domestic entities examined outside the state shall pay the traveling and maintenance expenses of examiners.**]**

(d) (1) The commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists to assist in conducting the examinations under this section as examiners, the cost of which shall be borne by the company that is the subject of the examination.

(2) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this section.

(3) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this section, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(4) This section shall not abrogate or modify any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision (2) of this subsection.

(5) A person identified in subdivision (2) of this subsection shall be entitled to an award of attorney's fees and costs if such person is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this section and the party bringing the action was not substantially justified in doing so. For the purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(e) Notwithstanding subdivision (1) of subsection (d) of this section, no domestic insurance company or other domestic entity subject to examination under this section shall pay as costs associated with the examination the salaries, fringe benefits, traveling and maintenance expenses of examining personnel of the Insurance Department engaged in such examination if such domestic company or entity is otherwise liable to an assessment levied under section 38a-47, except that a domestic insurance company or other domestic entity shall pay the traveling and maintenance expenses of examining personnel of the Insurance Department when such company or entity is examined outside the state.

(f) Nothing in this section shall be construed to prevent or prohibit the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Insurance Department of this or any other state or country, or to law enforcement officials of this or any other state or to any agency of the federal government at any time, as long as such agency or office receiving the report or matters relating thereto agrees in writing to hold such report or matters confidential.

(g) All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this section shall be given confidential treatment, shall not be subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subsection (f) of this section. Access to such working papers, recorded information, documents and copies may be granted by the commissioner to the National Association of Insurance Commissioners as long as it agrees, in writing, to hold such working papers, recorded information, documents and copies confidential.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Amusement Park Insurance Certificates

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

State Agency:
Insurance Department

Liaison: Debra Korta
Phone: 860.297.3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal: *Property/Casualty Division*

Agency Analyst/Drafter of Proposal: *Mike Malesta, counsel*

Title of Proposal
An Act Amending Amusement Park and Fireworks Statutes

Statutory Reference

Title 29, Sections 29-133, 29-139, 29-141, and 29-359

Proposal Summary

Current law requires amusement park and fireworks operators to be licensed and regulated by the Department of Consumer Protection and Emergency Services and Public Protection. The Insurance Department believes that the licensing process could be updated and modernized making them more business-friendly. Under current law, amusement park and fireworks operators are required to provide an Insurance Certificate evidencing financial responsibility to the Insurance Department as part of the process for receiving a license while all other licensing documentation is filed with the applicable licensing agency. The Insurance Department believes that it would be less burdensome to business if all licensing documentation and the processing thereof was filed and held by the applicable State agency granting a license to amusement and fireworks operators. This legislation continues to require evidence of financial responsibility but only proposes to remove the Insurance Department from receiving and holding insurance certificates required under existing law.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

(45) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? No
(46) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Unaware
(47) Have certain constituencies called for this action? No
(48) What would happen if this was not enacted in law this session? Collection of insurance certificates would remain with the Insurance Department.

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

If this is a resubmission, please share:

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

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

(48) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

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

PROPOSAL IMPACT

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

Agency Name: *Emergency Services and Public Protection (Fire and Explosion Investigation Unit) and the Department of Consumer Protection.*

Agency Contact (Gary Berner, Legislative Program Manager, DCP, 860-713-6208; Scott DeVico, Legislative Liaison, Dept. of Emergency Services, 860-256-0813; Terrence Reid, DAS, 860-713-5085)
Date Contacted: September 24th, 2012

Approve of Proposal ___ YES ___NO __X_Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)

None

State

None

Federal
None

Additional notes on fiscal impact

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

Sec. 29-133. Licensing of amusements; definitions. When used in sections 29-134 to 29-142, inclusive:

(1) "Amusement" means any circus or carnival presented in the open, including a place where one or more rides or devices capable of accommodating one or more passengers and normally requiring the supervision or services of an operator are presented for amusement or entertainment purposes, and any circus, carnival or other portable show or exhibition presented under any single tent, air-supported plastic or fabric or other portable shelter, and involving the assembly of one hundred or more persons. "Amusement" does not include an inflatable device leased for private residential use;

(2) "Commissioner" means the Commissioner of Consumer Protection;

(3) ["Insurance Commissioner" means the state Insurance Commissioner;]

([4]) "Grandstand" means any structure, either with or without a roof, providing seating for one hundred or more persons;

([5]4) "Owner" means the proprietor, operator, agent or possessor of such amusement;

([6]5) "Tent" means any structure with or without side panels having wood or metal supports and using any kind of a textile or similar material for coverage, and having a capacity sufficient to shelter one hundred or more persons or covering a ground area of more than one thousand two hundred square feet.

Sec. 29-139. Financial responsibility. Before exhibiting or providing any amusement in this state or engaging in the conduct of any place of amusement, entertainment, diversion or recreation to which an admission fee is charged and so located in any area which, with other places of amusement, entertainment, diversion or recreation, constitutes a public amusement park, the owner shall maintain a liability insurance policy issued by an insurer or an agent or representative thereof doing business in this state [furnish proof of financial responsibility] to satisfy claims for damages on account of any physical injuries or property damage arising out of the operation of such public amusement park suffered by any person by reason of any act or omission on the part of the owner, his agents or employees, any fair or exposition association, any sponsoring organization or committee, any owner or lessee of any premises used for such public amusement park or any public authority granting a permit to the owner, in the minimum amounts as determined from the following table:

Area of Largest Tent (sq. ft.)	**Combined Liability Per Accident**

No Tents	1,000,000
1 - 1,500	1,000,000
1,501 - 3,000	1,500,000
3,001 - 6,000	2,000,000
6,001 - 12,000	3,000,000
12,001 - 20,000	4,000,000
20,001 - 30,000	5,000,000
30,001 and over	6,000,000

For mechanical rides or devices capable of accommodating three or more persons, the following minimum amount shall apply: For bodily injury and property damage one million dollars per accident. Notwithstanding the provisions of this section, the minimum amount for owners of any waterslide ride or device shall be five hundred thousand dollars per accident. [The character and form of the financial responsibility shall be as the Insurance Commissioner determines to be necessary for the protection of the public.]

Sec. 29-141. Appeal. If any person is aggrieved by the doings of the commissioner [or Insurance Commissioner] under the provisions of sections 29-133 to 29-140, inclusive, he may apply to the superior court for any judicial district, which may grant appropriate relief.

Sec. 29-359. (Formerly Sec. 29-99). Financial responsibility, liability insurance policy. (a) Before any person, firm or corporation or any agent or employee thereof may conduct a fireworks display or use pyrotechnics for indoor special effects, such person, firm or corporation shall maintain a liability insurance policy issued by an insurer or an agent or representative thereof doing business in this state [furnish proof of financial responsibility] to satisfy claims for damages on account of any physical injury or property damage which may be suffered by any person by reason of any act or omission on the part of such person, firm or corporation, any agent or employee thereof, any independent contractor firing the display or using such pyrotechnics, any fair or exposition association, any sponsoring organization or committee, any owner or lessee of any premises used by the named insured and any public authority granting a permit to the named insured[in the form of a liability insurance policy evidenced by a certificate of insurance filed with the Insurance Commissioner at least fifteen days prior to the date of display or use and acceptable to the commissioner]. Such policy shall cover public liability arising out of the operation of the fireworks display or from the use of pyrotechnics for special effects in the minimum amount of one million dollars per accident for bodily injury and property damage, and shall not limit coverage within the applicable statutory period of covered liability. [The insurer issuing such policy shall agree in writing to deliver to the Insurance Commissioner not less than ten days' written notice of any cancellation of such insurance which is to become effective prior to the termination of the display or use.]

(b) The Commissioner of Public Safety shall adopt regulations in accordance with the provisions of chapter 54 defining the term "pyrotechnics" for purposes of subsection (a) of this section.

Agency Legislative Proposal - 2013 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
CID_100112_Home Address

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

State Agency:
Connecticut Insurance Department

Liaison: Debra J. Korta
Phone: (860) 297-3864
E-mail: debra.korta@ct.gov

Lead agency division requesting this proposal:
Hearing Officer

Agency Analyst/Drafter of Proposal:
Mark Franklin

Title of Proposal
AAC the Confidentiality of Insurance Department Employee Addresses

Statutory Reference 1-217

Proposal Summary
This proposal would prohibit the disclosure of Insurance Department employee residential addresses.

Reason for Proposal (Include significant policy and programmatic impacts)

Investigations and disciplinary actions involving Department licensees, or applicants for licenses, can be extremely volatile. In 2012, two employees of the Louisiana Insurance Department who were investigatin an agent were murdered, and previously an employee of the North Carolina Insurance Department who been investigating an agent was also slain. Similarly, investigations of consumer complaints can frequent become volatile.

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

PROPOSAL BACKGROUND

- **Reason for Proposal**

Please consider the following, if applicable:

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

(50) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Not aware

(51) Have certain constituencies called for this action? Employees of the Insurance Department

(52) What would happen if this was not enacted in law this session? No privacy or confidentiality provisions would be in place and employee addresses would continue to be subject to Freedom of Information requests.

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

If this is a resubmission, please share:

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

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

(52) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

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

PROPOSAL IMPACT

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

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

Approve of Proposal ___ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? ___ YES ___NO

- **Fiscal Impact** (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation)
N/A

State
N/A

Federal
N/A

Additional notes on fiscal impact

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

Sec. 1-217. (Formerly Sec. 1-20f). Nondisclosure of residential addresses of certain individuals. (a) No public agency may disclose, under the Freedom of Information Act, the residential address of any of the following persons:

(1) A federal court judge, federal court magistrate, judge of the Superior Court, Appellate Court or Supreme Court of the state, or family support magistrate;

(2) A sworn member of a municipal police department, a sworn member of the Division of State Police within the Department of Public Safety or a sworn law enforcement officer within the Department of Environmental Protection;

(3) An employee of the Department of Correction;

(4) An attorney-at-law who represents or has represented the state in a criminal prosecution;

(5) An attorney-at-law who is or has been employed by the Public Defender Services Division or a social worker who is employed by the Public Defender Services Division;

(6) An inspector employed by the Division of Criminal Justice;

(7) A firefighter;

(8) An employee of the Department of Children and Families;

(9) A member or employee of the Board of Pardons and Paroles;

(10) An employee of the judicial branch;

(11) An employee of the Department of Mental Health and Addiction Services who provides direct care to patients; or

(12) A member or employee of the Commission on Human Rights and Opportunities.

(13) An employee of the Insurance Department.

(b) The business address of any person described in this section shall be subject to disclosure under section 1-210. The provisions of this section shall not apply to Department of Motor Vehicles records described in section 14-10.