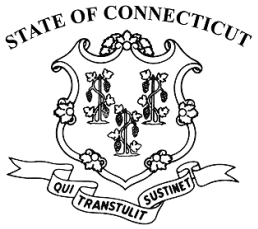

Substitute Senate Bill No. 906

Public Act No. 19-125

AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDED CHANGES TO THE INSURANCE STATUTES, INSURANCE PLANS PROCURED BY THE COMPTROLLER AND RETIREMENT PLANS.

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

Section 1. Section 38a-8 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) The commissioner shall see that all laws respecting insurance companies and health care centers are faithfully executed and shall administer and enforce the provisions of this title. The commissioner shall have all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to protect the public interest in accordance with the duties imposed by this title. The commissioner shall pay to the Treasurer all the fees that the commissioner receives. The commissioner may administer oaths in the discharge of the commissioner's duties.

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

(c) In addition to the specific regulations that the commissioner is

required to adopt, the commissioner may adopt such further regulations, in accordance with the provisions of chapter 54, as are reasonable and necessary to implement the provisions of this title.

(d) The commissioner shall develop a program of periodic review to ensure compliance by the Insurance Department with the minimum standards established by the National Association of Insurance Commissioners for effective financial surveillance and regulation of insurance companies operating in this state. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, pertaining to the financial surveillance and solvency regulation of insurance companies and health care centers as are reasonable and necessary to obtain or maintain the accreditation of the Insurance Department by the National Association of Insurance Commissioners. The commissioner shall maintain as confidential any confidential documents or information received from the National Association of Insurance Commissioners, or the International Association of Insurance Supervisors, or any documents or information received from state or federal insurance, banking or securities regulators or similar regulators in a foreign country that are confidential in such jurisdictions. The commissioner may share any information, including confidential information, with the National Association of Insurance Commissioners, the International Association of Insurance Supervisors, or state or federal insurance, banking or securities regulators or similar regulators in a foreign country, provided the commissioner determines that such entities agree to maintain the same level of confidentiality in their jurisdictions as is available in this state. At the expense of a domestic, alien or foreign insurer, the commissioner may engage the services of attorneys, actuaries, accountants and other experts not otherwise part of the commissioner's staff as may be necessary to assist the commissioner in the financial analysis of the insurer, the review of the insurer's license applications, and the review of transactions within a holding company system

involving an insurer domiciled in this state. No duties of a person employed by the Insurance Department on November 1, 2002, shall be performed by such attorney, actuary, accountant or expert.

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

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

(g) The commissioner may, in the commissioner's discretion, engage the services of such third-party actuaries, professionals and specialists that the commissioner deems necessary to assist the commissioner in reviewing any rate, form or similar filing submitted to the commissioner pursuant to this title. The cost of such services shall be borne by the person who submitted such rate, form or similar filing to the commissioner.

Sec. 2. Section 38a-37 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Pursuant to terms and conditions of this compact, the state of Connecticut seeks to join with other states and establish the Interstate Insurance Product Regulation Compact, and thus become a member of the Interstate Insurance Product Regulation Commission. The Insurance Commissioner is hereby designated to serve as the representative of this state to the commission.

ARTICLE I

PURPOSES

The purposes of this compact are, through means of joint and cooperative action among the compacting states:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II

DEFINITIONS

For purposes of this compact:

1. "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the rules and operating procedures of the commission.

2. "Bylaws" mean those bylaws established by the commission for its governance, or for directing or controlling the commission's actions or conduct.

3. "Compacting state" means any state which has enacted this compact legislation and which has not withdrawn pursuant to Article XIV, section 1 of this compact, or been terminated pursuant to Article XIV, section 2 of this compact.

4. "Commission" means the Interstate Insurance Product Regulation Commission established by this compact.

5. "Commissioner" means the chief insurance regulatory official of a state including, but not limited to, commissioner, superintendent, director or administrator.

6. "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of

entry.

7. "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this compact.

8. "Member" means the person chosen by a compacting state as its representative to the commission, or the member's designee.

9. "Non-compacting state" means any state which is not at the time a compacting state.

10. "Operating procedures" mean procedures promulgated by the commission implementing a rule, uniform standard or a provision of this compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the commission, including a uniform standard developed pursuant to Article VII of this compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the commission, which shall have the force and effect of law in the compacting states.

13. "State" means any state, district or territory of the United States of America.

14. "Third-party filer" means an entity that submits a product filing to the commission on behalf of an Insurer.

15. "Uniform standard" means a standard adopted by the

commission for a product line, pursuant to Article VII of this compact, and shall include all of the product requirements in aggregate; provided, that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable or against public policy as determined by the commission.

ARTICLE III

ESTABLISHMENT OF THE COMMISSION AND VENUE

1. The compacting states hereby create and establish a joint public agency known as the Interstate Insurance Product Regulation Commission. Pursuant to Article IV of this compact, the commission will have the power to develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards; provided, it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the state where filed.

2. The Interstate Insurance Product Regulation Commission is a body corporate and politic, and an instrumentality of the compacting states.

3. The commission is solely responsible for its liabilities except as otherwise specifically provided in this compact.

4. Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is

located.

ARTICLE IV

POWERS OF THE COMMISSION

The commission shall have the following powers:

1. To promulgate rules, pursuant to Article VII of this compact, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this compact;

2. To exercise its rulemaking authority and establish reasonable uniform standards for products covered under the compact, and advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the commission, provided, that a compacting state shall have the right to opt out of such uniform standard pursuant to Article VII of this compact, to the extent and in the manner provided in this compact, and, provided further, that any uniform standard established by the commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners require amending of the uniform standards established by the commission for long-term care insurance products;

3. To receive and review in an expeditious manner products filed

with the commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the compact;

4. To receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the commission, and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long-term care insurance products, the commission shall have the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the compact;

5. To exercise its rulemaking authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the commission;

6. To promulgate operating procedures, pursuant to Article VII of this compact, which shall be binding in the compacting states to the extent and in the manner provided in this compact;

7. To bring and prosecute legal proceedings or actions in its name as the commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a compacting state;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the compact, and determine their qualifications; and to establish the commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to compacting states as may be set forth in the bylaws, rules or operating procedures;

17. To enforce compliance by compacting states with rules, uniform standards, operating procedures and bylaws;

18. To provide for dispute resolution among compacting states;

19. To advise compacting states on issues relating to insurers domiciled or doing business in non-compacting jurisdictions, consistent with the purposes of this compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of the business of insurance.

ARTICLE V

ORGANIZATION OF THE COMMISSION

Section 1. Membership, Voting and Bylaws

a. Each compacting state shall have and be limited to one member. Each member shall be qualified to serve in that capacity pursuant to

applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which he or she shall be appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

b. Each member shall be entitled to one vote and shall have an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the commission with respect to the promulgation of a uniform standard shall be effective unless two-thirds of the members vote in favor thereof.

c. The commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the compact, including, but not limited to:

(i) Establishing the fiscal year of the commission;

(ii) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee;

(iii) Providing reasonable standards and procedures: (I) For the establishment and meetings of other committees, and (II) governing any general or specific delegation of any authority or function of the commission;

(iv) Providing reasonable procedures for calling and conducting meetings of the commission that consists of a majority of commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest,

the privacy of individuals, and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting in toto or in part. As soon as practicable, the commission must make public (I) a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed, and (II) votes taken during such meeting;

(v) Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the commission;

(vi) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the commission;

(vii) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

(viii) Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment and/or reserving of all of its debts and obligations.

d. The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compacting states.

Section 2. Management Committee, Officers and Personnel

a. A management committee comprising no more than fourteen members shall be established as follows:

(i) One member from each of the six compacting states with the

largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the National Association of Insurance Commissioners for the prior year;

(ii) Four members from those compacting states with at least two per cent of the market based on the premium volume described above, other than the six compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

(iii) Four members from those compacting states with less than two per cent of the market, based on the premium volume described above, with one selected from each of the four zone regions of the National Association of Insurance Commissioners as provided in the bylaws.

b. The management committee shall have such authority and duties as may be set forth in the bylaws, including, but not limited to:

(i) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission;

(ii) Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard; provided that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds of the members of the management committee;

(iii) Overseeing the offices of the commission; and

(iv) Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations

in order to advance the goals of the commission.

c. The commission shall elect annually officers from the management committee, with each having such authority and duties, as may be specified in the bylaws.

d. The management committee may, subject to the approval of the commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the commission may deem appropriate. The executive director shall serve as secretary to the commission, but shall not be a member of the commission. The executive director shall hire and supervise such other staff as may be authorized by the commission.

Section 3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the commission, including the management committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

b. The commission shall establish two advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

Section 4. Corporate Records of the Commission

The commission shall maintain its corporate books and records in accordance with the bylaws.

Section 5. Qualified Immunity, Defense and Indemnification

a. The members, officers, executive director, employees and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or wilful and wanton misconduct of that person.

b. The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or wilful and wanton misconduct.

c. The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment,

duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or wilful and wanton misconduct of that person.

ARTICLE VI

MEETINGS AND ACTS OF THE COMMISSION

1. The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

2. Each member of the commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

3. The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

ARTICLE VII

RULES AND OPERATING PROCEDURES: RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

1. The commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this compact. Notwithstanding the foregoing, in the event the commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this compact, or the powers granted hereunder, then such an action by the

commission shall be invalid and have no force and effect.

2. Rules and operating procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committees in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. A uniform standard shall become effective ninety days after its promulgation by the commission or such later date as the commission may determine; provided, however, that a compacting state may opt out of a uniform standard as provided in this article. "Opt out" shall be defined as any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure or amendment.

4. A compacting state may opt out of a uniform standard, either by legislation or regulation duly promulgated by the Insurance Department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by regulation, it must:

a. Give written notice to the commission no later than ten business days after the uniform standard is promulgated, or at the time the state becomes a compacting state; and

b. Find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state.

The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state which warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh: (i) The intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this compact; and (ii) the presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product. Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this compact. Such an opt out shall be effective at the time of enactment of this compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

5. If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective. Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective

effect as provided under Article XIV of this compact for withdrawals.

6. If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the commission, at least fifteen days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension thereof may postpone the effective date by up to ninety days, unless affirmatively extended by the commission; provided, a stay may not be permitted to remain in effect for more than one year unless the compacting state can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the compacting state from opting out. A stay may be terminated by the commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.

ARTICLE VIII

COMMISSION RECORDS AND ENFORCEMENT

1. The commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data or information to the commission; provided, that disclosure to the commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this compact, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the commission shall remain confidential after such information is provided to any commissioner.

3. The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any non-complying compacting state in writing of its noncompliance with commission bylaws, rules or operating procedures. If a non-complying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in Article XIV of this compact.

4. The commissioner of any state in which an insurer is authorized

to do business, or is conducting the business of insurance, shall continue to exercise the commissioner's authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following provisions:

a. With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission.

b. Before a commissioner may bring an action for violation of any provision, standard or requirement of the compact relating to the content of an advertisement not approved or certified to the commission, the commission, or an authorized commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the insurer, opportunity for hearing or disclosure of requests for authorization or records of the commission's action on such requests.

ARTICLE IX

DISPUTE RESOLUTION

The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and which may arise between two or more compacting states, or between compacting states and non-compacting states, and the commission shall promulgate an operating procedure providing for resolution of such disputes.

ARTICLE X

PRODUCT FILING AND APPROVAL

1. Insurers and third-party filers seeking to have a product approved by the commission shall file the product with, and pay applicable filing fees to, the commission. Nothing in this compact shall be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

2. The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the commission shall promulgate rules to establish conditions and procedures under which the commission will provide public access to product filing information. In establishing such rules, the commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

3. Any product approved by the commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

ARTICLE XI

REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

1. Not later than thirty days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall promulgate rules to establish procedures for appointing such review panels and provide for notice

and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, section 4 of this compact.

2. The commission shall have authority to monitor, review and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in section 1 of this article.

ARTICLE XII

FINANCE

1. The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, compacting states and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of its duties shall not be compromised.

2. The commission shall collect a filing fee from each insurer and third-party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

3. The commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this compact.

4. The commission shall be exempt from all taxation in and by the compacting states.

5. The commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

6. The commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports including the system of internal controls and procedures of the commission shall be audited annually by an independent certified public accountant. Upon the determination of the commission, but no less frequently than every three years, the review of the independent auditor shall include a management and performance audit of the commission. The commission shall make an annual report to the governor and legislature of the compacting states, which shall include a report of the independent audit. The commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No compacting state shall have any claim to or ownership of any property held by or vested in the commission or to any commission funds held pursuant to the provisions of this compact.

ARTICLE XIII

COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT

1. Any state is eligible to become a compacting state.

2. The compact shall become effective and binding upon legislative enactment of the compact into law by two compacting states; provided, the commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of, products filed with the commission that satisfy applicable uniform standards only after twenty-six states are compacting states or, alternatively, by states representing greater than forty per cent of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the National Association of Insurance Commissioners for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state.

3. Amendments to the compact may be proposed by the commission for enactment by the compacting states. No amendment shall become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law.

ARTICLE XIV

WITHDRAWAL, DEFAULT AND TERMINATION

Section 1. Withdrawal

a. Once effective, the compact shall continue in force and remain binding upon each and every compacting state; provided, that a compacting state may withdraw from the compact ("withdrawing state") by enacting a statute specifically repealing the statute which enacted the compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any

product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in paragraph e. of this section.

c. The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state.

d. The commission shall notify the other compacting states of the introduction of such legislation within ten days after its receipt of notice thereof.

e. The withdrawing state is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the compact.

Section 2. Default

a. If the commission determines that any compacting state has at any time defaulted ("defaulting state") in the performance of any of its

obligations or responsibilities under this compact, the bylaws or duly promulgated rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges and benefits conferred by this compact on the defaulting state shall be suspended from the effective date of default as fixed by the commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state shall be terminated from the compact and all rights, privileges and benefits conferred by this compact shall be terminated from the effective date of termination.

b. Product approvals by the commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to section 1 of this article.

c. Reinstatement following termination of any compacting state requires a reenactment of the compact.

Section 3. Dissolution of Compact

a. The compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the compact to one compacting state.

b. Upon the dissolution of this compact, the compact becomes null and void and shall be of no further force or effect, and the business and

affairs of the commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

ARTICLE XV

SEVERABILITY AND CONSTRUCTION

1. The provisions of this compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

2. The provisions of this compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI

BINDING EFFECT OF COMPACT AND OTHER LAWS

Section 1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in paragraph b. of this section.

b. For any product approved or certified to the commission, the rules, uniform standards and any other requirements of the commission shall constitute the exclusive provisions applicable to the content, approval and certification of such products. For advertisement that is subject to the commission's authority, any rule, uniform standard or other requirement of the commission which governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the commission shall abrogate or restrict:

(i) The access of any person to state courts;

(ii) Remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product;

(iii) State law relating to the construction of insurance contracts; or

(iv) The authority of the attorney general of the state, including, but not limited to, maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual states shall be subject to the laws of those states.

Section 2. Binding Effect of this Compact

a. All lawful actions of the commission, including all rules and operating procedures promulgated by the commission, are binding upon the compacting states.

b. All agreements between the commission and the compacting states are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of commission actions, and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the commission shall be ineffective as to that compacting state, and those obligations, duties, powers or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this compact

becomes effective.

ARTICLE XVII

STATE OF CONNECTICUT OPT OUT

In accordance with the provisions of Article VII, section 4 of this compact, the state of Connecticut opts out of all existing and prospective uniform standards involving long-term care insurance products **[**and all existing uniform standards involving disability income insurance products**]** in order to preserve the state's statutory requirements governing these insurance products.

Sec. 3. Subdivision (1) of subsection (d) of section 38a-156a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) (1) Upon approval by the commissioner of the proposed plan of reorganization, the board of directors, the chairperson of the board of directors or the president of the reorganizing insurer shall call a members' meeting to present and hold a vote on the plan of reorganization. Such meeting shall be held not earlier than thirty days after the date of the public hearing held under subsection (c) of this section. The plan shall be approved by an affirmative vote of two-thirds of the members of the reorganizing insurer voting.

Sec. 4. Section 38a-323a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) Each insurer that issues, renews, amends or endorses an automobile or homeowners insurance policy in this state on or after **[**October 1, 2017**]** July 1, 2019, shall include with the policy a conspicuous statement specifying that any individual may designate a third party to receive notice of cancellation or nonrenewal of the policy. The statement shall include a designation form, **[**and**]** a mailing

address and an electronic mail address the individual may use to designate a third party. Such statement shall be in a form approved by the Insurance Commissioner.

(b) No designation form shall be effective unless it contains a written acceptance by the third party designee to receive copies of notices of cancellation or nonrenewal from the insurer on behalf of the individual. The third party designation shall be effective not later than ten business days after the date the insurer receives the designation form and the acceptance of the third party. The third party may terminate the status as a third party designee by providing written notice to both the insurer and the insured individual. The individual may terminate the third party designation by providing written notice to the insurer and the third party designee. The insurer may require the individual and the third party to send the notices to the insurer by certified mail, return receipt requested, or, if agreed between the insurer and the individual or the insurer and the third party, by electronic means.

(c) The insurer's transmission to the third party designee of a copy of any notice of cancellation or nonrenewal shall be in addition to the transmission of the original document to the insured individual. When a third party is so designated, all such notices and copies shall be mailed in an envelope clearly marked on its face with, or, if agreed between the insurer and the third party, delivered by electronic means stating, the following: "IMPORTANT INSURANCE POLICY INFORMATION: OPEN IMMEDIATELY". The copy of the notice of cancellation or nonrenewal transmitted to the third party shall be governed by the same law and policy provisions that govern the notice being transmitted to the insured individual. The designation of a third party shall not constitute acceptance of any liability on the part of the third party or insurer for services provided to the insured individual.

Sec. 5. Subsection (a) of section 38a-324 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) After a policy of commercial risk insurance, other than workers' compensation insurance and automobile insurance issued under a residual market mechanism as described in section 38a-329, has been in effect for more than sixty days, or after the effective date of a renewal policy, no insurer may cancel any policy unless the cancellation is based on the occurrence, after the effective date of the policy or renewal, of one or more of the following conditions: (1) Nonpayment of premium; (2) conviction of a crime arising out of acts increasing the hazard insured against; (3) discovery of fraud or material misrepresentation by the insured in obtaining the policy or in perfecting any claim thereunder; (4) discovery of any wilful or reckless act or omission by the insured increasing the hazard insured against; (5) physical changes in the property which increase the hazard insured against; (6) a determination by the commissioner that continuation of the policy would violate or place the insurer in violation of the law; (7) a material increase in the hazard insured against; or (8) a substantial loss of reinsurance by the insurer affecting this particular line of insurance. If the basis for cancellation is nonpayment of premium, at least ten days' advance notice shall be given and the insured may continue the coverage and avoid the effect of the cancellation by payment in full at any time prior to the effective date of cancellation. If the basis for cancellation is conviction of a crime arising out of acts increasing the hazard insured against, discovery of fraud or material misrepresentation by the insured in obtaining the policy or in perfecting any claim thereunder, discovery of any wilful or reckless act or omission by the insured increasing the hazard insured against or a determination by the commissioner that continuation of the policy would violate or place the insurer in violation of the law, at least ten days' advance notice shall be given. In all other cases, at least sixty days' advance notice shall be given. Notwithstanding the provisions of

this section, the advance notice period for cancellation of any professional liability policy, as defined in section 38a-393, shall be at least ninety days. No notice of cancellation shall be required if such policy is transferred from an insurer to an affiliate of such insurer for another policy with no interruption of coverage and contains the same terms, conditions and provisions, including policy limits, as the transferred policy, except that the insurer to which the policy is transferred shall not be prohibited from applying its rates and rating plans at the time of renewal. No notice of cancellation shall be effective unless it is sent, by registered or certified mail**,** **[**or by**]** mail evidenced by a United States Post Office certificate of mailing or, if agreed between the insurer and the named insured, by electronic means evidenced by a delivery receipt, or delivered by the insurer to the named insured by the required date.

Sec. 6. Subsection (a) of section 38a-724 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) The use of an employment contract between a public adjuster and the insured shall be mandatory.

(1) Any such contract signed on or after **[**October 1, 2013**]** July 1, 2019, shall contain a provision, prominently displayed on the first page of such contract in not less than twelve-point boldface type, specifying that the insured may cancel the contract, provided such insured notifies the public adjuster at such public adjuster's main office or branch office at the address shown in the contract, by certified mail, return receipt requested, or, if agreed between the insured and the public adjuster, by electronic means with proof of a delivery receipt, posted or delivered not later than midnight of the fourth calendar day after the day on which the insured signs the contract, except that if the signing is on a Friday, Saturday or Sunday, the cancellation shall be posted not later than midnight of the Thursday immediately following,

and thereafter the contract shall be void ab initio.

(2) Any such contract signed on or after **[**October 1, 2013**]** July 1, 2019, that does not display the provision as specified in subdivision (1) of this subsection shall be void ab initio.

Sec. 7. Subsection (a) of section 38a-771 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) Any person, firm, partnership, association or corporation holding a license issued pursuant to sections 38a-702b, 38a-702j, 38a-703 to 38a-716, inclusive, 38a-731 to 38a-735, inclusive, 38a-769 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794 or holding a license in the name of a trade name shall notify the Insurance Commissioner, in writing, not later than thirty days after any: (1) Change in business **[**or**]** address, residence address or electronic mail address; (2) change in employer; (3) change in name; or (4) change in licensed **[**members of a firm, partnership, association or officers of a corporation**]** insurance producer responsible for ensuring compliance by such person, firm, partnership, association or corporation with the insurance laws, rules and regulations of this state, as stated in the application for license filed in this state by such person, firm, partnership, association or corporation.

Sec. 8. Section 38a-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) Before issuing any certificate of authority to any health care center on or after July 1, 1990, the commissioner shall require that a health care center have: (A) An initial net worth of one million five hundred thousand dollars, and (B) agree to thereafter maintain the minimum net worth required under subdivision (4) of this subsection.

(2) No health care center shall be licensed to transact business in this

state or remain so licensed unless, (A) its net worth bears a reasonable relationship to its liabilities based upon the type, volume and nature of business transacted, and (B) its risk-based capital related to its total adjusted capital is adequate for the type of business transacted. As used in this subsection, "total adjusted capital" means the sum of a health care center's net worth and any other item in the nature of capital as deemed appropriate by the commissioner; and "risk-based capital" means the net worth of the health care center adjusted to recognize the level of risk inherent in its business, including (i) risk with respect to the health care center's assets, (ii) the risk of adverse underwriting experience with respect to the health care center's liabilities and obligations, (iii) the credit risk with respect to the health care center's business, and (iv) all other business risks and such other relevant risks as the commissioner may determine.

(3) (A) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated. (B) The interest expenses relating to the repayment of any fully subordinated debt shall not be considered uncovered expenditures. (C) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(4) Except as provided in subdivision (3) and subdivisions (5) to (7), inclusive, of this subsection, each health care center shall maintain a minimum net worth equal to the greater of: (A) One million dollars; or (B) two per cent of its annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium revenues plus one per cent of annual premium revenues in excess of one hundred fifty million dollars. No health care center authorized by the

commissioner to do business in this state, on July 1, 1990, shall be required to comply with the provisions of subparagraph (B) of this subdivision until January 1, 1995.

(5) Each health care center that offers or proposes to offer out-of-network benefits shall either:

(A) Enter into an agreement with a duly licensed insurance company to provide coverage to subscribers and enrollees outside of the health care center's established network, subject to approval by the commissioner; or

(B) Implement an out-of-network benefit system to be operated by the health care center, subject to approval by the commissioner, provided the health care center establishes and maintains its net worth at an amount equal to the greater of (i) three million dollars, (ii) two per cent of its annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium revenues plus one per cent of annual premium revenues in excess of one hundred fifty million dollars, or (iii) two months of its cost of uncovered expenditures. For purposes of this subsection, "annual premium revenues" does not include revenue earned as a result of an arrangement between a health care center and the federal Centers for Medicare and Medicaid Services, on a cost or risk basis, for services to a Medicare beneficiary, or revenue earned as a result of an arrangement between a health care center and a Medicaid state agency, for services to a Medicaid beneficiary. For the purposes of this subsection, the uncovered expenditures of the health care center for the requisite two-month period shall be calculated as follows:

$$UE = \frac{(X + Y - Z)}{6}$$

Where:

UE = Uncovered expenditures of the health care center for the requisite two-month period.

X = Total year-to-date uncovered expenditures reported in the health care center's most recent statutory quarterly or annual statement.

Y = Total year-to-date uncovered expenditures reported in the health care center's annual statement for the prior calendar year.

Z = Total year-to-date uncovered expenditures reported in the health care center's statutory quarterly or annual statement for the current calendar quarter of the prior calendar year.

(6) The total cost of the out-of-network benefits of a health care center shall not exceed ten per cent of the total cost of the health care center's claims and expenses on a quarterly basis without the prior approval of the commissioner. **[**and the effectuation of an uncovered expenditures insolvency deposit established with the commissioner pursuant to section 38a-193a.**]**

(7) Any health care center that provides out-of-network benefits pursuant to this subsection shall provide a quarterly report concurrent with filing of the required quarterly and annual financial statements which shall demonstrate compliance with the provisions of this subsection.

(8) The commissioner may adopt regulations, in accordance with chapter 54, to implement the purposes of this subsection, including, but not limited to, provisions concerning: (A) The preparation and filing of reports by health care centers relating to risk-based capital levels and the calculation thereof; (B) the preparation and filing of

comprehensive financial plans when such capital levels are reduced below minimum threshold levels; (C) the confidentiality of such reports and plans; and (D) the regulatory corrective actions the commissioner may take in the event minimum risk-based capital levels are not maintained, or the health care center's financial plans filed with the commissioner are deficient, or the health care center fails to otherwise comply with the provisions of the regulations.

(b) Every health care center shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims. Such liabilities shall be calculated in accordance with those accounting procedures and practices prescribed by the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, version effective January 1, 2001, and subsequent revisions and the National Association of Insurance Commissioners Annual Statement Instructions, subject to any deviations prescribed by the commissioner.

(c) (1) Every contract between a health care center and a participating provider of health care services shall be in writing and shall contain the following provisions or variations approved by the commissioner:

"(A) (Name of provider or facility) .... hereby agrees that in no event, including, but not limited to, nonpayment by (name of health care center) ...., (name of health care center's) .... insolvency, or breach of this contract shall (name of provider or facility) .... bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or person acting on their behalf, other than (name of health care center) ...., for services

provided pursuant to this contract. This provision shall not prohibit collection of cost-sharing amounts, or costs for noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from covered persons in accordance with the terms of the covered person's health plan.

(B) (Name of provider or facility).... agrees, in the event of (name of health care center's) .... insolvency, to continue to provide the services promised in this contract to covered persons of (name of health care center) .... for the duration of the period for which premiums on behalf of the covered person were paid to (name of health care center) .... or until the covered person's discharge from inpatient facilities, whichever time is greater.

(C) Notwithstanding any other provision in this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the covered person's health plan.

(D) (Name of provider or facility).... may not bill the covered person for covered services, except for cost-sharing amounts, where (name of health care center) .... denies payment because the provider or facility has failed to comply with the terms or conditions of this contract.

(E) (Name of provider or facility) .... further agrees (i) that the provisions of subparagraphs (A), (B), (C) and (D) of this subdivision (or citations appropriate to the contract form) .... shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of (name of health care center's) .... covered persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (name of provider or facility) .... and covered persons or persons acting on their behalf.

(F) If (name of provider or facility) .... contracts with other providers or facilities who agree to provide covered services to covered persons of (name of health care center) .... with the expectation of receiving payment directly or indirectly from (name of health care center) ...., such providers or facilities shall agree to abide by the provisions of subparagraphs (A), (B), (C), (D) and (E) of this subsection (or citations appropriate to the contract form) ....."

(2) In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the provisions required by subdivision (1) of this subsection, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health care center.

(3) No participating provider, or agent, trustee or assignee thereof, may: (A) Maintain any action at law against a subscriber or enrollee to collect sums owed by the health care center; (B) request payment from a subscriber or enrollee for such sums; (C) request payment from a subscriber or enrollee for covered emergency services that are provided by an out-of-network provider; or (D) request payment from a subscriber or enrollee for a surprise bill, as defined in section 38a-477aa. For purposes of this subdivision "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "THIS IS NOT A BILL". The contract between a health care center and a participating provider shall inform the participating provider that pursuant to section 20-7f, it is an unfair trade practice in violation of chapter 735a for any health care provider to request payment from a subscriber or an enrollee, other than a coinsurance, copayment, deductible or other out-of-pocket expense, for covered medical or emergency services or facility fees, as defined in section

19a-508c, or surprise bills, or to report to a credit reporting agency an enrollee's failure to pay a bill for such services when a health care center has primary responsibility for payment of such services, fees or bills.

[(d) The commissioner shall require that each health care center have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined to inpatient facilities on the date of insolvency until their discharge or expiration of benefits. In considering such a plan, the commissioner may approve one or more of the following: (1) Insurance to cover the expenses to be paid for continued benefits after an insolvency; (2) provisions in provider contracts that obligate the provider to provide services after the health care center's insolvency for the duration of the period for which premium payment has been made and until the enrollees' discharge from inpatient facilities; (3) insolvency reserves; (4) acceptable letters of credit; or (5) any other arrangements to assure that benefits are continued as specified above.**]**

[(e)**]** (d) Every agreement to provide health care services between a provider and a health care center shall require the provider to provide at least sixty days' advance notice to the health care center to terminate the agreement.

[(f) (1) Unless otherwise provided in this subsection, each health care center shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodian or controlled account is utilized, cash, securities or any combination of cash or securities or other measures that are acceptable to the commissioner, which at all times shall have a value of not less than five hundred thousand dollars.

(2) A health care center that is in operation on October 1, 2007, shall make a deposit equal to two hundred fifty thousand dollars. In the second year, the amount of the additional deposit for a health care center that is in operation on October 1, 2007, shall be equal to two hundred fifty thousand dollars, for a total of five hundred thousand dollars.

(3) The deposit shall be an admitted asset of the health care center in the determination of net worth.

(4) All income from deposits shall be an asset of the organization. A health care center that has made a securities deposit may withdraw such deposit or any part thereof after making a substitute deposit of cash, securities or any combination of cash or securities or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited.

(5) The deposit shall be used to protect the interests of the health care center's enrollees and to assure continuation of health care services to enrollees of a health care center that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health care center is placed in rehabilitation or liquidation, the deposit shall be an asset subject to the provisions of the Insurers Rehabilitation and Liquidation Act.**]**

Sec. 9. Subsection (a) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Comptroller, with the approval of the Attorney General and of the Insurance Commissioner, shall arrange and procure a group hospitalization and medical and surgical insurance plan or plans for (1) state employees, (2) members of the General Assembly who elect

coverage under such plan or plans, (3) participants in an alternate retirement program who meet the service requirements of section 5-162 or subsection (a) of section 5-166, (4) anyone receiving benefits under section 5-144 or from any state-sponsored retirement system, except the teachers' retirement system and the municipal employees retirement system, (5) judges of probate and Probate Court employees, (6) the surviving spouse, and any dependent children of a state police officer, a member of an organized local police department, a firefighter or a constable who performs criminal law enforcement duties who dies before, on or after June 26, 2003, as the result of injuries received while acting within the scope of such officer's or firefighter's or constable's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan. Coverage for a dependent child pursuant to this subdivision shall terminate no earlier than the **[**policy anniversary date on or after**]** end of the calendar year during whichever of the following occurs first, the date on which the child: Becomes covered under a group health plan through the dependent's own employment; or attains the age of twenty-six, (7) employees of the Capital Region Development Authority established by section 32-601, and (8) the surviving spouse and dependent children of any employee of a municipality who dies on or after October 1, 2000, as the result of injuries received while acting within the scope of such employee's employment and not as the result of illness or natural causes, and whose surviving spouse and dependent children are not otherwise eligible for a group hospitalization and medical and surgical insurance plan. For purposes of this subdivision, "employee" means any regular employee or elective officer receiving pay from a municipality, "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, flood commission or authority established by special act

or regional council of governments. For purposes of subdivision (6) of this subsection, "firefighter" means any person who is regularly employed and paid by any municipality for the purpose of performing firefighting duties for a municipality on average of not less than thirty-five hours per week. The minimum benefits to be provided by such plan or plans shall be substantially equal in value to the benefits that each such employee or member of the General Assembly could secure in such plan or plans on an individual basis on the preceding first day of July. The state shall pay for each such employee and each member of the General Assembly covered by such plan or plans the portion of the premium charged for such member's or employee's individual coverage and seventy per cent of the additional cost of the form of coverage and such amount shall be credited to the total premiums owed by such employee or member of the General Assembly for the form of such member's or employee's coverage under such plan or plans. On and after January 1, 1989, the state shall pay for anyone receiving benefits from any such state-sponsored retirement system one hundred per cent of the portion of the premium charged for such member's or employee's individual coverage and one hundred per cent of any additional cost for the form of coverage. The balance of any premiums payable by an individual employee or by a member of the General Assembly for the form of coverage shall be deducted from the payroll by the State Comptroller. The total premiums payable shall be remitted by the Comptroller to the insurance company or companies or nonprofit organization or organizations providing the coverage. The amount of the state's contribution per employee for a health maintenance organization option shall be equal, in terms of dollars and cents, to the largest amount of the contribution per employee paid for any other option that is available to all eligible state employees included in the health benefits plan, but shall not be required to exceed the amount of the health maintenance organization premium.

Sec. 10. Subsection (a) of section 38a-503b of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469.

Sec. 11. Subsection (a) of section 38a-530b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) As used in this section, "carrier" means each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469.

Sec. 12. Subsection (b) of section 38a-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469 delivered, issued for delivery or renewed on or after October 1, 1989, or continued as defined in section 38a-531, on or after October 1, 1990, shall provide benefits for preventive pediatric care for any child covered by the policy or contract at approximately the following age intervals: Every two months from birth to six months of age, every three months from nine to eighteen months of age and annually from two through six years of age. Any such policy may provide that

services rendered during a periodic review shall be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. On and after January 1, 2009, each such policy shall also provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to section 19a-111g. Such benefits shall be subject to any policy provisions which apply to other services covered by such policy.

Sec. 13. Section 7-464c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(a) For the purposes of this section, "retirement plan" means any retirement plan created in accordance with the provisions of Section 403(b) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, that is not made available through the State Comptroller pursuant to subsection (c) of section 5-264.

[(a)**]** (b) On or after January 1, **[**2019**]** 2021, any company that administers a retirement plan offered by a political subdivision of the state to the employees of such political subdivision shall disclose to each participant in such retirement plan and the State Comptroller, in an electronic form and manner prescribed by the State Comptroller:

(1) The fee ratio and return, net of fees, for each investment under the retirement plan; **[**, and**]**

(2) **[**the**]** The fees paid to any person who, for compensation, engages in the business of providing investment advice to participants in the retirement plan either directly or through publications or writings; **[**. Such disclosures shall be made upon initial enrollment in the retirement plan and at least annually thereafter. For the purposes of this section, "retirement plan" means any retirement plan created in

accordance with the provisions of Section 403(b) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, that is not made available through the State Comptroller pursuant to subsection (c) of section 5-264 of the general statutes.**]** and

(3) Any other information required to be disclosed pursuant to 29 CFR 2550.404a-5 (d), as amended from time to time, if such retirement plan is a participant-directed individual account plan, as such term is used in 29 CFR 2550.404a-5.

[(b)**]** (c) Any such company shall be deemed to comply with the requirements of subsection **[**(a)**]** (b) of this section if such company adheres to the disclosure requirements for plans governed by the Employee Retirement Income Security Act of 1974 set forth in Section 2550.404a-5 of the Code of Federal Regulations, as in effect on July 1, 2017, or as amended from time to time, provided any amended disclosure requirements are substantially similar to those in effect on July 1, 2017.

(d) Each company that is subject to the disclosure requirements established in subsection (b) of this section shall make the disclosures required by said subsection upon initial enrollment in the retirement plan and at least annually thereafter.

(e) Not later than March 1, 2022, and annually thereafter, the State Comptroller shall post, on the State Comptroller's Internet web site, each disclosure that the State Comptroller received pursuant to subsection (b) of this section on or before the January first immediately preceding for the calendar year immediately preceding.

Sec. 14. (*Effective from passage*) Sections 12, 14, 15 and 16 of public act 18-158 shall take effect July 1, 2019.

Sec. 15. Section 38a-193a of the general statutes is repealed. (*Effective*

from passage)

Sec. 16. Sections 13 and 17 of public act 18-158 are repealed. (*Effective from passage*)