PA 24-138—sHB 5503
Commerce Committee
Insurance and Real Estate Committee

AN ACT CONCERNING INSURANCE MARKET CONDUCT AND INSURANCE LICENSING, THE INSURANCE DEPARTMENT'S TECHNICAL CORRECTIONS AND OTHER REVISIONS TO THE INSURANCE STATUTES AND CAPTIVE INSURANCE

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SUMMARY: This act makes numerous unrelated changes to insurance statutes, as summarized in the section-by-section analysis below.
EFFECTIVE DATE: October 1, 2024, unless otherwise stated below.

§§ 1 & 2 — INSURANCE COMMISSIONER'S ENFORCEMENT AUTHORITY

Allows the insurance commissioner to impose restitution, with interest, when someone violates the state's insurance laws, regulations, or commissioner orders; allows the commissioner to ask the attorney general to apply for a court order enforcing insurance laws and commissioner orders or providing restitution with interest

By law, the insurance commissioner must administer and enforce the laws on insurance companies and health care centers (i.e., HMOs). Relatedly, the law grants him the reasonable and necessary powers to protect the public interest.

The act explicitly allows the commissioner to order restitution of any amount obtained in violation of the state's insurance laws, regulations, or commissioner orders, plus interest as allowed under another state law. This is generally 10% interest per year (CGS § 37-3a).

The act also allows the commissioner to ask the attorney general to apply to Superior Court for an order (1) restraining and enjoining a person from violating any Title 38a provision (i.e., the insurance laws); (2) enforcing any commissioner-imposed order, penalty, or remedy; or (3) for restitution, with interest, for the

amount the person obtained in violation of the insurance laws. (Under existing law, the commissioner may already ask the attorney general to apply to Superior Court for a permanent or temporary order restraining a person from violating the insurance laws (CGS § 38a-16(b)).)

Additionally, state law allows the commissioner to enforce the insurance laws, and impose a penalty or remedy authorized by them, against any person even if the person's license or registration has been surrendered or has lapsed. The act also allows him to take these actions if the person's license or registration has been revoked.

§ 3 — 30 DAYS TO TURN OVER DOCUMENTS

Sets a 30-day deadline to comply with an Insurance Department request to provide documents related to an investigation

By law, the insurance commissioner may conduct investigations and hearings on any matter under the insurance laws. He may, among other things, order the production of books, records, papers, or documents for an investigation.

The act requires that anyone who receives a request to produce books, records, papers, or documents comply with the order within 30 days after the date of the order. By law, if a person refuses to comply, the commissioner may ask the Superior Court to order compliance.

§§ 4 & 5 — EXPIRATION DATE FOR CERTAIN INITIAL LICENSES

Revises the expiration date for initial licenses issued to motor vehicle damage appraisers and casualty claims adjusters from June 30 in an odd-numbered year to two years after the licensee's birthday preceding the license's issuance

Under prior law, initial licenses for motor vehicle damage appraisers and casualty claim adjusters expired on June 30 of the odd-numbered year following the license issuance, unless revoked or suspended earlier. The act changes this expiration date to two years after the licensee's birthday preceding the date the license was issued, unless it was already revoked or suspended. By law, a licensee may renew the license every two years at the insurance commissioner's discretion with payment of the required renewal fees.

§ 6 — GENERAL INSURANCE ASSESSMENT PROCESS

Removes the Office of the Healthcare Advocate from the Insurance Department's annual process of assessing carriers for the general insurance assessment

By law, domestic insurers and HMOs pay an annual assessment to the Insurance Department to cover the expenses of the Insurance Department, Office of the Healthcare Advocate, and Office of Health Strategy, among other things.

Under prior law, the insurance commissioner and the Office of the Healthcare Advocate assessed the entities following a process set in state law. The act removes the Office of the Healthcare Advocate from this process, leaving the insurance

commissioner to manage the assessment process.

It also makes technical and conforming changes.

§§ 7, 8 & 12 — ELECTRONIC FILINGS IN LIEU OF PAPER FILINGS

Removes requirements that insurers file copies of annual financial statements and audited financial reports with the insurance commissioner, allowing electronic filings to the NAIC to suffice

Prior law required domestic insurers, HMOs, and fraternal benefit societies to file copies of annual financial statements and audited financial reports with the insurance commissioner as well as electronically with the National Association of Insurance Commissioners (NAIC). The act eliminates the requirement to submit these to the commissioner. Instead, it deems the companies' electronic submissions to the NAIC to have been filed with the commissioner.

§ 9 — NON-ENGLISH INSURANCE DOCUMENTS AND TRANSLATIONS

Requires insurers who file policies in a non-English language to certify that they comply with readable language requirements and bear the risks associated with any translations; allows the insurance commissioner to hire translation services at the insurer's cost

By law, insurance policies filed with the Insurance Department must meet certain readability standards (e.g., Flesch reading ease scores and print specifications). As under prior law, the act allows insurers to file policies in any language. The insurer must certify that the policy complies with the readability standards or is translated from a policy that complies.

The act allows the insurance commissioner to hire a translation service to review a non-English-language policy filed by an insurer. The insurer that filed the policy must pay the cost of the translation. Alternatively, the commissioner may require the insurer to provide an English-translated copy of the policy and a certification as to the translation's accuracy. The act requires the insurer to accept all risks associated with a translation.

The act also allows the commissioner to adopt implementing regulations.

§ 10 — PHARMACY BENEFIT MANAGER REPORT DUE DATE

Moves up the annual due date for PBMs to report rebate information to the insurance commissioner by one month; requires the commissioner to give the PBMs a copy of his annual report to the Insurance and Real Estate Committee at least 10 days before it is due to the committee

By law, each pharmacy benefit manager (PBM) must annually file a report on prescription drug rebates with the insurance commissioner. Under prior law, the report was due by March 1. The act moves up the due date to February 1, beginning in 2025.

The law also requires the commissioner to report annually to the Insurance and Real Estate Committee by March 1 on the PBMs' rebate reports. Under prior law,

the commissioner had to give the PBMs an advanced copy of this report by February 1 annually. The act instead requires him to provide the copy at least 10 days before he reports to the committee.
EFFECTIVE DATE: January 1, 2025

§ 11 — SMALL EMPLOYER DEFINITION

Beginning January 1, 2025, updates the state's definition of "small employer" in the health insurance statutes to mean having no more than 50 employees

Beginning January 1, 2025, the act defines "small employer" under the health insurance laws to mean an employer with an average of at least one and no more than 50 employees on business days in the prior calendar year and at least one employee on the first day of the group health insurance plan year.

Prior law extended the definition to employers with an average of no more than 100 employees, except that the insurance commissioner could postpone that definition to be consistent with the federal Affordable Care Act. (The commissioner did so in Insurance Bulletin HC-106 (2015). So, in practice, the small employer definition has been no more than an average of 50 employees since before 2016.)

§ 13 — INDEPENDENT REVIEW ORGANIZATION ACCREDITATION PERIOD

Extends the accreditation approval or reapproval period for independent review organizations from two to three years

By law, the insurance commissioner maintains a list of accredited independent review organizations available to conduct regular or expedited external reviews of health insurance grievances. The act extends the accreditation period from two years under prior law to three. As under existing law, if the commissioner determines that an organization no longer meets the minimum requirements for accreditation, he must end its approval and remove it from the list of approved organizations.

§§ 14 & 15 — CAPTIVE INSURER CONVERSION OF PROTECTED CELLS

Allows a captive insurer's protected cell to convert into a new protected cell, incorporated cell, or captive insurance company without any impact on the protected cell's assets, rights, benefits, obligations, and liabilities

Captive Insurer

Generally, a captive insurer is an insurance company formed to insure or reinsure the risks of its owners, parent company, or affiliated company. The law allows several different types of captive insurers to be licensed and operate in the state, including a sponsored captive insurer.

A sponsored captive insurer is an insurance company (1) for which one or more sponsors provide the minimum paid-in capital and surplus, (2) that insures its

participants through separate participant contracts, and (3) that funds its liability to each participant through protected cells and separates each cell's assets from that of other cells and the captive insurer as a whole. PA 23-15 allowed these protected cells to establish, with the insurance commissioner's prior written approval, separate accounts and allocate assets to them, subject to certain requirements.

Conversion of Protected Cell Allowed

The act allows sponsored captive insurers to convert protected or incorporated protected cells into one of the following other insurance company structures or types of accounts:

1. a single protected or incorporated protected cell;
2. a new sponsored captive insurer (including those licensed as a special purpose financial captive insurer);
3. a new special purpose financial captive, pure captive, agency captive, industrial insured captive, or association captive insurer; or
4. a new risk retention group.

Any conversion is deemed to (1) be a continuation of the cell's existence, with all of its assets, rights, benefits, obligations, and liabilities, and (2) occur without any transfer or assignment of these assets, rights, benefits, obligations, and liabilities and without creating any reversionary interest in or impairment of them. The act specifies that the conversion does not limit any rights or protections applicable to the cell or the sponsored captive that existed before the conversion.

Conversion Process

Under the act, a sponsored captive must apply to the insurance commissioner and receive his prior written approval for the conversion. Additionally, the act subjects the conversion to the existing laws regulating captives and the sponsored captive insurer's plan of operation approved by the commissioner, without affecting the converted cell's assets, rights, benefits, obligations, and liabilities.

For cells that convert into an incorporated protected cell or a new captive insurer or risk retention group, the conversion must follow all existing business corporation or limited liability company laws that apply to the newly formed business or legal entity.

§ 16 — COVERED CONNECTICUT PROGRAM

Requires the Covered Connecticut program to include only in-network providers and services, unless the insurance commissioner determines the health carrier's network is inadequate

By law, the Covered Connecticut program provides eligible individuals with health insurance, including dental benefits and non-emergency medical transport, at no out-of-pocket cost to them.

The act requires that the program only include in-network providers and services, unless the insurance commissioner determines the health carrier's network is inadequate. Eligible individuals will only receive the benefits and cost-sharing

subsidies available under the program if they use in-network providers or facilities.

§§ 17 & 18 — CONNECTICUT CLEARINGHOUSE REPEALED

Repeals a requirement that the Health Reinsurance Association develop the Connecticut Clearinghouse on health insurance policies available in the state

Prior law required the Health Reinsurance Association to develop the Connecticut Clearinghouse as a resource for individuals and small employers to get information on health insurance policies and plans available in the state. The act repeals this requirement. (The clearinghouse has largely been replaced by the health insurance exchange, Access Health CT.)
EFFECTIVE DATE: Upon passage