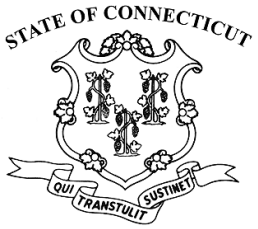

Substitute House Bill No. 6391

Public Act No. 21-157

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

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

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 Subsections (b) and (c) of section 19a-7p of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

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

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

(3) (A) Not later than September first, annually, each such insurer or health care center shall report to the Insurance Commissioner, in the form and manner prescribed by **[**said**]** the commissioner, the number of insured or enrolled lives in this state as of May first immediately preceding the date for which such insurer or health care center is

providing health insurance that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans. The commissioner may require each such insurer or health care center or any other person to submit to the commissioner any records that are in such insurer's, health care center's or other person's possession if such records were used to prepare such insurer's or health care center's annual report submitted pursuant to this subparagraph.

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

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

(c) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each such insurer and health care center. Such fee shall be calculated by multiplying the number of lives reported to said commissioner pursuant to subparagraph (A) of subdivision (3) of subsection (b) of this section by a factor, determined annually by said commissioner as set forth in this subsection, to fully fund the aggregate amount determined under subsection (a) of this section. The Insurance

Commissioner shall determine the factor by dividing the aggregate amount by the total number of lives reported to said commissioner pursuant to subparagraph (A) of subdivision (3) of subsection (b) of this section.

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

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

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

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

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

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

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

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

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

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

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

(7) "Licensee" means any person licensed, authorized to operate or registered, or required to be licensed, authorized to operate or

registered, pursuant to the insurance laws of this state, **[**except for**]** including, but not limited to, a fraternal benefit society, an interlocal risk management agency formed pursuant to chapter 113a or an employers' mutual association authorized under part C of chapter 568, but not including a purchasing group or **[**a**]** risk retention group chartered and licensed in another state, **[**or**]** a **[**licensee that is**]** person acting as an assuming insurer and domiciled in another state or jurisdiction or a commissioner of the Superior Court acting as a title agent, as defined in section 38a-402.

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

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

provision of health care to a consumer; or (iii) payment for the provision of health care to a consumer.

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

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

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

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

(c) Information Security Program. (1) Implementation of an information security program. Except as provided in subdivision (10) of this subsection, each licensee shall, not later than October 1, **[**2020**]** 2021, develop, implement and maintain a comprehensive written information security program that is based on the licensee's risk assessment and contains the administrative, technical and physical safeguards for the protection of nonpublic information and such licensee's information systems. Each information security program shall be commensurate

with the size and complexity of the licensee, the nature and scope of the licensee's activities, including, but not limited to, such licensee's use of third-party service providers, and the sensitivity of the nonpublic information used by such licensee or in such licensee's possession, custody or control.

(2) Objectives of Information Security Program. Except as provided in subdivision (10) of this subsection, each information security program developed, implemented and maintained by a licensee pursuant to subdivision (1) of this subsection shall:

(A) Be designed to:

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

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

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

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

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

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

(B) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration or destruction of nonpublic information, including, but not

limited to, the security of information systems that are, and nonpublic information that is, accessible to, or held by, third-party service providers;

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

(D) Assess the sufficiency of policies, procedures, information systems and other safeguards in place to manage the threats identified pursuant to subparagraph (B) of this subdivision by considering such threats in the following areas of such licensee's operations:

(i) Employee training and management;

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

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

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

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

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

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

custody or control.

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

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

(ii) Identification and management of the data, personnel, devices, systems and facilities that enable such licensee to achieve such licensee's business purposes in accordance with their relative importance to such licensee's business objectives and risk strategy;

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

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

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

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

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

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

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

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

(xi) Development, implementation and maintenance of procedures for the secure disposal of nonpublic information in any format.

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

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

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

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

(A) Require the licensee's executive management or **[**its**]** such executive management's delegates to develop, implement and maintain

such licensee's information security program.

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

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

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

(C) If a licensee's executive management delegates any of **[**its**]** such executive management's responsibilities under subparagraph (A) or (B) of this subdivision, **[**it**]** such executive management shall oversee the development, implementation and maintenance of the licensee's information security program prepared by the delegate or delegates, and shall receive a report from such delegate or delegates that satisfies the requirements established in subparagraph (B) of this subdivision.

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

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

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

providers.

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

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

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

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

(ii) The goals of such incident response plan;

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

(iv) External and internal communications;

(v) Information sharing;

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

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

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

(9) Annual Certification to Commissioner of Domiciliary State. Except as provided in subdivision (10) of this subsection, each insurer, health care center or fraternal benefit society domiciled in this state shall submit to the Insurance Commissioner a written statement, not later than **[**February**]** April fifteenth, annually, certifying that such insurer, health care center or fraternal benefit society is in compliance with the requirements set forth in this subsection. **[**Each insurer shall**]** A domestic insurer, health care center or fraternal benefit society that is a member of an insurance holding company system, as defined in section 38a-129, may submit one statement to the Insurance Commissioner on behalf of other domestic insurers, health care centers or fraternal benefit societies that are members of the same insurance holding company system, not later than April fifteenth, annually, certifying that such domestic members of the insurance holding company system are in compliance with the requirements set forth in this subsection. Each insurer, health care center or fraternal benefit society shall, either directly or through an affiliate, maintain, for examination by the Insurance Department, all records, schedules and data supporting each statement that such insurer, health care center or fraternal benefit society, or a member of an insurance holding company system acting on behalf of such insurer, health care center or fraternal benefit society, submits to the commissioner for a period of five years. To the extent an insurer, health care center or fraternal benefit society has identified areas, systems or processes that require material improvement, updating or redesign, the insurer, health care center or fraternal benefit society shall, either

directly or through an affiliate, document such identification and the remedial efforts planned and underway to address such areas, systems or processes. Such documentation must be available for inspection by the commissioner.

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

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

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

(ii) Each licensee that is subject to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and has established and maintains an information security program pursuant to said act and the rules, regulations, procedures or guidelines established thereunder, shall be deemed to have satisfied the requirements of this subsection, provided such licensee is in compliance therewith and submits to the Insurance Commissioner, not later than April fifteenth, annually, a written statement certifying such licensee's compliance therewith;

(iii) Each employee, agent, representative or designee of a licensee, who is also a licensee, shall be exempt from the provisions of this subsection and need not develop its own information security program

to the extent that such employee, agent representative or designee is covered by the other licensee's information security program; and

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

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

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

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

(A) Determine whether the cybersecurity event occurred; and

(B) If the cybersecurity event occurred:

(i) Assess the nature and scope of such cybersecurity event;

(ii) Identify the nonpublic information, if any, that may have been

involved in such cybersecurity event; and

(iii) Perform or oversee reasonable measures to restore the security of the information systems compromised in such cybersecurity event in order to prevent further unauthorized acquisition, release or use of nonpublic information that is in the licensee's possession, custody or control.

(3) If a licensee learns that a cybersecurity event has, or may have, occurred in a system maintained by a third-party service provider, the licensee shall complete the steps listed in subdivision (2) of this subsection or confirm and document that the third-party service provider has completed such steps.

(4) Each licensee that is subject to the provisions of this subsection shall maintain records concerning each cybersecurity event for a period of at least five years from the date of such cybersecurity event, and shall produce such records to the Insurance Commissioner upon demand by the commissioner.

(e) Notification of a Cybersecurity Event. (1) Notification to the Commissioner. Each licensee shall notify the Insurance Commissioner that a cybersecurity event has occurred, as promptly as possible but in no event later than three business days after the date **[**of the**]** on which such licensee first determines that a cybersecurity event has occurred, if:

(A) Such licensee is an insurer and this state is the insurer's state of domicile, or the licensee is an insurance producer, as defined in section 38a-702a, and this state is the insurance producer's home state, as defined in section 38a-702a, **[**;**]** and it is reasonably likely that the cybersecurity event will materially harm:

(i) A consumer residing in this state; or

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

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

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

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

(I) A consumer residing in this state; or

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

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

(i) The date of the cybersecurity event;

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

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

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

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

(vi) Whether such licensee has filed a police report or notified any

regulatory, government or law enforcement agency, and, if so, when such licensee filed such report or provided such notice;

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

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

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

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

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

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

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

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

(3) Notification to Consumers. Each licensee shall comply with all

applicable provisions of section 36a-701b, and provide to the Insurance Commissioner a copy of the notice that such licensee sends to consumers pursuant to said section, if any, if such licensee is required to notify the commissioner pursuant to subdivision (1) of this subsection.

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

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

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

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

(ii) Each ceding insurer that has a direct contractual relationship with

the consumers affected by a cybersecurity event shall fulfill the consumer notification requirements imposed under section 36a-701b and any other notification requirements relating to a cybersecurity event imposed under this section.

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

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

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

(f) Power of Commissioner. (1) The Insurance Commissioner shall

have power to examine and investigate into the affairs of a licensee to determine whether the licensee is, or has been, engaged in conduct in this state that violates the provisions of this section. The commissioner's power under this subsection is in addition to the commissioner's powers under sections 38a-14 to 38a-16, inclusive. Any such investigation or examination shall be conducted pursuant to said sections, if applicable.

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

(A) A statement setting forth such violation; and

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

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

(i) Enforcing the provisions of this section; or

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

(B) The Insurance Commissioner may, after holding a hearing pursuant to subparagraph (A) of this subdivision, take any action that is necessary or appropriate to enforce the provisions of this section and, in addition to or in lieu of suspending, revoking or refusing to reissue or renew any license, certificate of registration or authorization to

operate the commissioner has issued, or may issue, to the licensee, impose on such licensee a civil penalty of not more than fifty thousand dollars for each violation of the provisions of this section. The commissioner may bring a civil action to recover the amount of any civil penalty that the commissioner imposes on a licensee pursuant to this subparagraph.

(g) Confidentiality. (1) (A) Except as provided in subparagraph (B) of this subdivision, documents, materials and other information in the possession, custody or control of the Insurance Department and furnished to the department by a licensee, or an employee or agent of a licensee acting on behalf of the licensee, pursuant to subdivision (9) of subsection (c) of this section or subparagraph (A)(ii), (A)(iii), (A)(iv), (A)(v), (A)(viii), (A)(x) or (A)(xi) of subdivision (2) of subsection (e) of this section, or obtained by the commissioner in an investigation or examination conducted pursuant to subsection (f) of this section, shall be confidential by law, privileged, not subject to disclosure under section 1-210, not subject to subpoena, and not subject to discovery or admission into evidence in any private civil action.

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

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

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

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

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

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

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

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

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

(6) All documents, materials and other information provided to, and in the possession, custody or control of, the National Association of Insurance Commissioners or a third-party consultant or vendor pursuant to this section shall be confidential by law, privileged, not be subject to disclosure under section 1-210, not subject to subpoena, and not subject to discovery or admission into evidence in any private civil action.

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

(g) If the actual expenditures for the fall prevention program established in section 17a-303a are less than the amount allocated, the Commissioner of Aging and Disability Services shall notify the Insurance Commissioner and the Healthcare Advocate. Immediately following the close of the fiscal year, the Insurance Commissioner and the Healthcare Advocate shall recalculate the proposed assessment for each domestic insurance company or other domestic entity in accordance with subsection (c) of this section using the actual expenditures made during the fiscal year by the Insurance Department,

the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund, the actual expenditures made on behalf of the department and the offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and the actual expenditures for the fall prevention program. On or before July thirty-first, the Insurance Commissioner and the Healthcare Advocate shall render to each such domestic insurance company and other domestic entity a statement showing the difference between their respective recalculated assessments and the amount they have previously paid. On or before August thirty-first, the Insurance Commissioner and the Healthcare Advocate, after receiving any objections to such statements, shall make such adjustments which in their opinion may be indicated, and shall render an adjusted assessment, if any, to the affected companies. Any such domestic insurance company or other domestic entity may pay to the Insurance Commissioner the entire assessment required under this subsection in one payment when the first installment of such assessment is due.

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

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

[(2) (A) All requests for external review or expedited external review shall be accompanied by a filing fee of twenty-five dollars, except that no covered person or covered person's authorized representative shall pay more than seventy-five dollars in a calendar year for such covered

person. Any filing fee paid by a covered person's authorized representative shall be deemed to have been paid by the covered person. If the commissioner finds that the covered person is indigent or unable to pay the filing fee, the commissioner shall waive such fee. Any such fees shall be deposited in the Insurance Fund established under section 38a-52a.

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

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

[(4)**]** (3) An external review decision, whether such review is a standard external review or an expedited external review, shall be binding on the health carrier or a self-insured governmental plan and the covered person, except to the extent such health carrier or covered person has other remedies available under federal or state law. A covered person or a covered person's authorized representative shall not file a subsequent request for an external review or an expedited external review that involves the same adverse determination or final adverse determination for which the covered person or the covered person's authorized representative already received an external review decision or an expedited external review decision.

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

[(6)**]** (5) Each independent review organization shall maintain written

records as set forth in subsection (e) of section 38a-591m.

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

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

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

(2) The written notice shall include:

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

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

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

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

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

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

(ii) If the final adverse determination concerns (I) an admission,

availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person or the covered person's authorized representative may file a request for an expedited external review, or (II) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may file a request for an expedited external review;

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

(ii) As part of any forms provided under subparagraph (D)(i) of this subdivision, an authorization form or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508, as amended from time to time, by which the covered person shall authorize the health carrier and the covered person's treating health care professional to release, transfer or otherwise divulge, in accordance with sections 38a-975 to 38a-999a, inclusive, the covered person's protected health information including medical records for purposes of conducting an external review or an expedited external review;

(E) A statement that the covered person or the covered person's authorized representative may request, free of charge, copies of all documents, communications, information and evidence regarding the

adverse determination or the final adverse determination that were not previously provided to the covered person or the covered person's authorized representative.

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

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

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

(A) An adverse determination, if:

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

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

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

(B) A final adverse determination if:

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

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

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

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

(e) (1) Not later than one hundred twenty calendar days after a covered person or a covered person's authorized representative receives a notice of an adverse determination or a final adverse determination, the covered person or the covered person's authorized representative may file a request for an external review or an expedited external review with the commissioner in accordance with this section.

(2) Not later than one business day after the commissioner receives a

request that is complete, the commissioner shall: **[**send**]**

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

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

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

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

(B) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan but for the health carrier's determination that the health care service is not covered because **[**it**]** the health care service does not meet the health carrier's

requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

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

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

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

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

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

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

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

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

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

(II) Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to

treat the covered person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or the final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

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

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

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

(B) If the external review or the expedited external review is accepted, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the health carrier shall include in such notice (i) a statement that the covered person or the

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

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

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

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

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

[(D)**]** (E) Notwithstanding a health carrier's initial determination that a request for an external review or an expedited external review is ineligible for review, the commissioner may determine, pursuant to the terms of the covered person's health benefit plan, that such request is

eligible for such review and assign an independent review organization to conduct such review. Any such review shall be conducted in accordance with this section.

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

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

(B) Notify the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the commissioner shall include in such notice (i) a statement that the covered person or the covered person's authorized representative may submit, not later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, additional information in writing to the assigned independent review organization that such organization shall consider when conducting the external review, and (ii) where and how such additional information is to be submitted. If additional information is submitted later than five business days after the covered person or the

covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information.**]**

[(2)**]** (f) (1) Not later than five business days for an external review or one calendar day for an expedited external review, after the health carrier **[**receives notice of the name of the assigned independent review organization from the commissioner**]** accepts the external review or expedited external review, the health carrier or its designee utilization review company shall provide to the assigned independent review organization the documents and any information such health carrier or utilization review company considered in making the adverse determination or the final adverse determination.

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

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

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

(g) (1) The assigned independent review organization shall review all

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

(2) Not later than one business day after receiving any information submitted by the covered person or the covered person's authorized representative pursuant to subparagraph (B) of subdivision **[**(1)**]** (4) of subsection **[**(f)**]** (e) of this section, the independent review organization shall forward such information to the health carrier.

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

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

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

(h) In addition to the documents and information received pursuant to subsection (f) of this section, the independent review organization shall consider, to the extent the documents or information are available

and the independent review organization considers them appropriate, the following in reaching a decision:

(1) The covered person's medical records;

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

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

(4) The terms of coverage under the covered person's health benefit plan to ensure that the independent review organization's decision is not contrary to the terms of coverage under such health benefit plan;

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

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

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

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

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

such review;

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

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

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

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

(2) Such notice shall include:

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

(B) The date the independent review organization received the

assignment from the commissioner to conduct the review;

(C) The date the review was conducted;

(D) The date the organization made its decision;

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

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

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

(H) For a review involving a determination that the recommended or requested health care service or treatment is experimental or investigational:

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

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

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

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

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

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

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

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

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

[(2)**]** (B) Subsection (c) of this section;

[(3)**]** (C) Subsections (d) and (h) of this section;

[(4)**]** (D) Subsections (e), (h) and (i) of this section;

[(5)**]** (E) Subsections (f) and (i) of this section;

[(6)**]** (F) Subsection (g) of this section; **[**or**]**

(G) Subsection (h) of this section; or

[(7)**]** (H) Any regulation adopted pursuant to subsection (b) of section 38a-88, as amended by this act.

(2) Credit shall be allowed under subsection (b), (c) or (d) of this section only as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write

or assume in its state of domicile, or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under subsection (d) or (e) of this section only if the applicable requirements of subsection (i) of this section have been satisfied.

(b) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(c) (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state. To be eligible for accreditation, an insurer shall (A) file with the commissioner evidence of its submission to this state's jurisdiction, (B) submit to this state's authority to examine its books and records, (C) be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state, (D) file annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement, and (E) demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from a domestic insurer. An assuming insurer shall be deemed to meet the requirements of this subparagraph if it maintains a surplus with regard to policyholders of not less than twenty million dollars at the time of accreditation and its accreditation has not been denied by the commissioner within ninety days after the date the insurer submitted its application.

(2) Each accredited reinsurer doing business in this state shall, annually, on or before the first day of March, submit to the commissioner, by electronically filing with the National Association of Insurance Commissioners, a true and complete report, signed and

sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall be deemed to have been submitted to the commissioner in accordance with this subdivision.

(d) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable in this state and the assuming insurer or United States branch of an alien assuming insurer (1) maintains a surplus with regard to policyholders in an amount not less than twenty million dollars, and (2) submits to the authority of this state to examine its books and records. The requirement of subdivision (1) of this subsection shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(e) (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust that complies with the requirements of subdivisions (2) and (3) of this subsection in a qualified United States financial institution, as defined in section 38a-87, for the payment of the valid claims of its United States policyholders and ceding insurers, and their assigns and successors in interest. The assuming insurer shall (A) report annually to the commissioner

information substantially the same as that required to be reported in the National Association of Insurance Commissioners' Annual Statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund, and (B) submit to, and pay the expenses of, examination of its books and records by the commissioner.

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

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

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

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

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

(ii) Not later than March first, annually, the trustee of the trust shall (I) report to the commissioner, in writing, the balance and a list of the investments of the trust at the end of the preceding calendar year, and (II) certify to the commissioner the date of termination of the trust, if so

planned, or that the trust will not expire prior to the following December thirty-first.

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

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

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

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

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

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

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

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

(iv) Not later than ninety days after its financial statements are due to be filed with the group's domiciliary insurance regulatory official, the group shall provide to the commissioner an annual certification by the group's domiciliary insurance regulatory official of the solvency of each underwriter who is a member of the group or, if such certification is not provided by the group's domiciliary insurance regulatory official, financial statements prepared by independent public accountants of each such underwriter.

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

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

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

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

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

(f) (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is certified in accordance with section 38a-85a by the commissioner as a reinsurer in this state and such certified reinsurer maintains security in a form and amounts set forth in subdivision (3) of subsection (e) of this section or, for a multibeneficiary trust set forth in subdivision (2) of subsection (e) of section 38a-85a, in accordance with the provisions of subdivision (2) of subsection (e) of section 38a-85a.

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

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

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

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

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

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

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

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

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

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

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

(ii) The assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as

agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this provision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

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

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

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

(E) The assuming insurer or its legal successor shall provide, if

requested by the commissioner, on behalf of itself and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner in regulation.

(F) The assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in regulation.

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

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

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

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

(B) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance

with a process set forth in regulations adopted by the commissioner pursuant to chapter 54, except that the commissioner shall not remove from the list a reciprocal jurisdiction as defined under subparagraphs (A)(i) and (A)(ii) of subdivision (1) of this subsection. Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to this section and sections 38a-85a to 38a-88, inclusive, as amended by this act.

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

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

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

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

(5) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

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

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

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

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

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

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

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

[(i)**]** (j) If the assuming insurer does not meet the requirements of subsection (b), (c), **[**or**]** (d) or (g) of this section, the credit permitted by

subsection (e) or (f) of this section shall not be allowed unless the assuming insurer agrees to the following conditions in the trust instrument:

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

(2) The trust assets shall be distributed by and claims filed with and valued by the insurance regulatory official with principal regulatory oversight of the trust in accordance with the laws of the trust's state of domicile that are applicable to the liquidation of domestic insurance companies;

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

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

[(j)**]** (k) (1) (A) The commissioner may suspend or revoke a reinsurer's accreditation or certification if, after notice and hearing, the

commissioner finds such reinsurer no longer meets the requirements for accreditation or certification.

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

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

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

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

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

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

(B) If a reinsurer's accreditation or certification is revoked, no credit shall be allowed under this section on and after the effective date of such revocation, except to the extent that such reinsurer's obligations under such contract are secured in accordance with the provisions of

subsection (e) of section 38a-85a or section 38a-86.

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

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

[(k)**]** (l) (1) A domestic ceding insurer shall manage its reinsurance recoverables in proportion to its own book of business. Such insurer shall notify the commissioner not later than thirty days after (A) reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers exceed fifty per cent of the domestic ceding insurer's last reported surplus to policyholders, or (B) the domestic ceding insurer determines that reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers are likely to exceed such limit. Any such notice shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

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

domestic ceding insurer.

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

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

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

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

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

(b) (1) The commissioner may adopt regulations in accordance with the provisions of chapter 54 to establish, in addition to the requirements of sections 38a-85, as amended by this act, and 38a-86, requirements relating to or setting forth (A) the valuation of assets or reserve credits, (B) the circumstances under which credit will be reduced or eliminated, and (C) the amounts and forms of security supporting reinsurance

agreements relating to (i) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits, (ii) universal life insurance policies with provisions that permit a policyholder to keep such policy in force over a secondary guarantee period, (iii) variable annuities with guaranteed death or living benefits, (iv) long-term care insurance policies, or (v) any other life insurance, health insurance or annuity products for which the National Association of Insurance Commissioners adopts model regulatory credit for reinsurance requirements.

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

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

[(B)**]** (4) **[**Shall**]** Any regulation adopted pursuant to this subsection shall not apply to cessions to an assuming insurer **[**(i)**]** that (A) meets the conditions set forth in subsection (g) of section 38a-85, as amended by this act, (B) is certified as a reinsurer in accordance with the provisions of section 38a-85a, or **[**(ii) (I) that**]** (C) maintains at least two hundred fifty million dollars in capital and surplus, determined in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, including all amendments adopted by the National Association of Insurance Commissioners and excluding the impact of any permitted or prescribed practices, and **[**(II)**]** (i) is

licensed in at least twenty-six states, or (ii) is licensed in at least ten states and licensed or accredited in a total of at least thirty-five states.

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

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

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

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

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

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

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

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

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