



General Assembly

January Session, 2021

Raised Bill No. 6391

LCO No. 2705



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***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:

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2 statutes are repealed and the following is substituted in lieu thereof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

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

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

13 (3) (A) Not later than September first, annually, each such insurer or
14 health care center shall report to the Insurance Commissioner, in the

15 form and manner prescribed by [said] the commissioner, the number of
16 insured or enrolled lives in this state as of May first immediately
17 preceding the date for which such insurer or health care center is
18 providing health insurance that provides coverage of the types specified
19 in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Such number
20 shall not include lives enrolled in Medicare, any medical assistance
21 program administered by the Department of Social Services, workers'
22 compensation insurance or Medicare Part C plans. The commissioner
23 may require each such insurer or health care center or any other person
24 to submit to the commissioner any records that are in such insurer's,
25 health care center's or other person's possession if such records were
26 used to prepare such insurer's or health care center's annual report
27 submitted pursuant to this subparagraph.

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

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

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

48 amount determined under subsection (a) of this section. The Insurance
49 Commissioner shall determine the factor by dividing the aggregate
50 amount by the total number of lives reported to said commissioner
51 pursuant to subparagraph (A) of subdivision (3) of subsection (b) of this
52 section.

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

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

63 [(b) On or before January fifteenth annually, the commissioner shall
64 submit to the joint standing committee of the General Assembly having
65 cognizance of matters relating to insurance a report, in accordance with
66 the provisions of section 11-4a, detailing all the information the
67 commissioner received during the past year pursuant to sections 29-311,
68 31-290d, 38a-356 and 53-445.]

69 Sec. 3. Subsections (b) to (g), inclusive, of section 38a-38 of the general
70 statutes are repealed and the following is substituted in lieu thereof
71 (*Effective October 1, 2021*):

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

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

77 (2) "Consumer" means an individual, including, but not limited to, an

78 applicant, beneficiary, certificate holder, claimant, insured or
79 policyholder, who is a resident of this state and whose nonpublic
80 information is in a licensee's possession, custody or control.

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

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

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

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

104 (7) "Licensee" means any person licensed, authorized to operate or
105 registered, or required to be licensed, authorized to operate or
106 registered, pursuant to the insurance laws of this state, [except for]
107 including, but not limited to, a fraternal benefit society, an interlocal risk
108 management agency formed pursuant to chapter 113a or an employers'
109 mutual association authorized under part C of chapter 568, but not

110 including a purchasing group or [a] risk retention group chartered and
111 licensed in another state, [or] a [licensee that is] person acting as an
112 assuming insurer and domiciled in another state or jurisdiction or a
113 commissioner of the Superior Court acting as a title agent, as defined in
114 section 38a-402.

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

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

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

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

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

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

158 (c) Information Security Program. (1) Implementation of an
159 information security program. Except as provided in subdivision (10) of
160 this subsection, each licensee shall, not later than October 1, [2020] 2021,
161 develop, implement and maintain a comprehensive written information
162 security program that is based on the licensee's risk assessment and
163 contains the administrative, technical and physical safeguards for the
164 protection of nonpublic information and such licensee's information
165 systems. Each information security program shall be commensurate
166 with the size and complexity of the licensee, the nature and scope of the
167 licensee's activities, including, but not limited to, such licensee's use of
168 third-party service providers, and the sensitivity of the nonpublic
169 information used by such licensee or in such licensee's possession,
170 custody or control.

171 (2) Objectives of Information Security Program. Except as provided
172 in subdivision (10) of this subsection, each information security
173 program developed, implemented and maintained by a licensee

174 pursuant to subdivision (1) of this subsection shall:

175 (A) Be designed to:

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

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

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

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

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

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

190 (B) Identify reasonably foreseeable internal or external threats that
191 could result in unauthorized access, transmission, disclosure, misuse,
192 alteration or destruction of nonpublic information, including, but not
193 limited to, the security of information systems that are, and nonpublic
194 information that is, accessible to, or held by, third-party service
195 providers;

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

199 (D) Assess the sufficiency of policies, procedures, information
200 systems and other safeguards in place to manage the threats identified
201 pursuant to subparagraph (B) of this subdivision by considering such

202 threats in the following areas of such licensee's operations:

203 (i) Employee training and management;

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

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

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

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

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

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

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

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

228 (ii) Identification and management of the data, personnel, devices,
229 systems and facilities that enable such licensee to achieve such licensee's

230 business purposes in accordance with their relative importance to such
231 licensee's business objectives and risk strategy;

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

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

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

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

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

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

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

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

258 (xi) Development, implementation and maintenance of procedures

259 for the secure disposal of nonpublic information in any format.

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

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

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

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

272 (A) Require the licensee's executive management or [its] such
273 executive management's delegates to develop, implement and maintain
274 such licensee's information security program.

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

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

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

286 (C) If a licensee's executive management delegates any of [its] such
287 executive management's responsibilities under subparagraph (A) or (B)

288 of this subdivision, [it] such executive management shall oversee the
289 development, implementation and maintenance of the licensee's
290 information security program prepared by the delegate or delegates,
291 and shall receive a report from such delegate or delegates that satisfies
292 the requirements established in subparagraph (B) of this subdivision.

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

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

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

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

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

320 the continuing functionality of any aspect of such licensee's business or
321 operations.

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

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

324 (ii) The goals of such incident response plan;

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

327 (iv) External and internal communications;

328 (v) Information sharing;

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

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

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

335 (9) Annual Certification to Commissioner of Domiciliary State.
336 Except as provided in subdivision (10) of this subsection, each insurer,
337 health care center or fraternal benefit society domiciled in this state shall
338 submit to the Insurance Commissioner a written statement, not later
339 than [February] April fifteenth, annually, certifying that such insurer,
340 health care center or fraternal benefit society is in compliance with the
341 requirements set forth in this subsection. [Each insurer shall] A domestic
342 insurer, health care center or fraternal benefit society that is a member
343 of an insurance holding company system, as defined in section 38a-129,
344 may submit one statement to the Insurance Commissioner on behalf of
345 other domestic insurers, health care centers or fraternal benefit societies
346 that are members of the same insurance holding company system, not
347 later than April fifteenth, annually, certifying that such domestic

348 members of the insurance holding company system are in compliance
349 with the requirements set forth in this subsection. Each insurer, health
350 care center or fraternal benefit society shall, either directly or through
351 an affiliate, maintain, for examination by the Insurance Department, all
352 records, schedules and data supporting each statement that such
353 insurer, health care center or fraternal benefit society, or a member of an
354 insurance holding company system acting on behalf of such insurer,
355 health care center or fraternal benefit society, submits to the
356 commissioner for a period of five years. To the extent an insurer, health
357 care center or fraternal benefit society has identified areas, systems or
358 processes that require material improvement, updating or redesign, the
359 insurer, health care center or fraternal benefit society shall, either
360 directly or through an affiliate, document such identification and the
361 remedial efforts planned and underway to address such areas, systems
362 or processes. Such documentation must be available for inspection by
363 the commissioner.

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

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

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

377 (ii) Each licensee that is subject to the Health Insurance Portability
378 and Accountability Act of 1996, P.L. 104-191, as amended from time to
379 time, and has established and maintains an information security

380 program pursuant to said act and the rules, regulations, procedures or
381 guidelines established thereunder, shall be deemed to have satisfied the
382 requirements of this subsection, provided such licensee is in compliance
383 therewith and submits to the Insurance Commissioner, not later than
384 April fifteenth, annually, a written statement certifying such licensee's
385 compliance therewith;

386 (iii) Each employee, agent, representative or designee of a licensee,
387 who is also a licensee, shall be exempt from the provisions of this
388 subsection and need not develop its own information security program
389 to the extent that such employee, agent representative or designee is
390 covered by the other licensee's information security program; and

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

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

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

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

412 (A) Determine whether the cybersecurity event occurred; and

413 (B) If the cybersecurity event occurred:

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

415 (ii) Identify the nonpublic information, if any, that may have been
416 involved in such cybersecurity event; and

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

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

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

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

437 (A) Such licensee is an insurer and this state is the insurer's state of
438 domicile, or the licensee is an insurance producer, as defined in section
439 38a-702a, and this state is the insurance producer's home state, as
440 defined in section 38a-702a, [;] and it is reasonably likely that the
441 cybersecurity event will materially harm:

442 (i) A consumer residing in this state; or

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

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

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

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

452 (I) A consumer residing in this state; or

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

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

459 (i) The date of the cybersecurity event;

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

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

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

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

468 (vi) Whether such licensee has filed a police report or notified any
469 regulatory, government or law enforcement agency, and, if so, when
470 such licensee filed such report or provided such notice;

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

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

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

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

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

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

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

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

495 (3) Notification to Consumers. Each licensee shall comply with all
496 applicable provisions of section 36a-701b, and provide to the Insurance

497 Commissioner a copy of the notice that such licensee sends to
498 consumers pursuant to said section, if any, if such licensee is required
499 to notify the commissioner pursuant to subdivision (1) of this
500 subsection.

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

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

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

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

524 (ii) Each ceding insurer that has a direct contractual relationship with
525 the consumers affected by a cybersecurity event shall fulfill the
526 consumer notification requirements imposed under section 36a-701b
527 and any other notification requirements relating to a cybersecurity event
528 imposed under this section.

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

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

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

554 (f) Power of Commissioner. (1) The Insurance Commissioner shall
555 have power to examine and investigate into the affairs of a licensee to
556 determine whether the licensee is, or has been, engaged in conduct in
557 this state that violates the provisions of this section. The commissioner's
558 power under this subsection is in addition to the commissioner's powers
559 under sections 38a-14 to 38a-16, inclusive. Any such investigation or
560 examination shall be conducted pursuant to said sections, if applicable.

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

565 (A) A statement setting forth such violation; and

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

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

574 (i) Enforcing the provisions of this section; or

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

578 (B) The Insurance Commissioner may, after holding a hearing
579 pursuant to subparagraph (A) of this subdivision, take any action that
580 is necessary or appropriate to enforce the provisions of this section and,
581 in addition to or in lieu of suspending, revoking or refusing to reissue
582 or renew any license, certificate of registration or authorization to
583 operate the commissioner has issued, or may issue, to the licensee,
584 impose on such licensee a civil penalty of not more than fifty thousand
585 dollars for each violation of the provisions of this section. The
586 commissioner may bring a civil action to recover the amount of any civil
587 penalty that the commissioner imposes on a licensee pursuant to this
588 subparagraph.

589 (g) Confidentiality. (1) (A) Except as provided in subparagraph (B) of
590 this subdivision, documents, materials and other information in the

591 possession, custody or control of the Insurance Department and
592 furnished to the department by a licensee, or an employee or agent of a
593 licensee acting on behalf of the licensee, pursuant to subdivision (9) of
594 subsection (c) of this section or subparagraph (A)(ii), (A)(iii), (A)(iv),
595 (A)(v), (A)(viii), (A)(x) or (A)(xi) of subdivision (2) of subsection (e) of
596 this section, or obtained by the commissioner in an investigation or
597 examination conducted pursuant to subsection (f) of this section, shall
598 be confidential by law, privileged, not subject to disclosure under
599 section 1-210, not subject to subpoena, and not subject to discovery or
600 admission into evidence in any private civil action.

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

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

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

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

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

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

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

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

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

654 (6) All documents, materials and other information provided to, and

655 in the possession, custody or control of, the National Association of
656 Insurance Commissioners or a third-party consultant or vendor
657 pursuant to this section shall be confidential by law, privileged, not be
658 subject to disclosure under section 1-210, not subject to subpoena, and
659 not subject to discovery or admission into evidence in any private civil
660 action.

661 Sec. 4. Subsection (g) of section 38a-48 of the general statutes is
662 repealed and the following is substituted in lieu thereof (*Effective July 1,*
663 *2021*):

664 (g) If the actual expenditures for the fall prevention program
665 established in section 17a-303a are less than the amount allocated, the
666 Commissioner of Aging and Disability Services shall notify the
667 Insurance Commissioner and the Healthcare Advocate. Immediately
668 following the close of the fiscal year, the Insurance Commissioner and
669 the Healthcare Advocate shall recalculate the proposed assessment for
670 each domestic insurance company or other domestic entity in
671 accordance with subsection (c) of this section using the actual
672 expenditures made during the fiscal year by the Insurance Department,
673 the Office of the Healthcare Advocate and the Office of Health Strategy
674 from the Insurance Fund, the actual expenditures made on behalf of the
675 department and the offices from the Capital Equipment Purchase Fund
676 pursuant to section 4a-9, not including such expenditures made on
677 behalf of the Health Systems Planning Unit of the Office of Health
678 Strategy, and the actual expenditures for the fall prevention program.
679 On or before July thirty-first, the Insurance Commissioner and the
680 Healthcare Advocate shall render to each such domestic insurance
681 company and other domestic entity a statement showing the difference
682 between their respective recalculated assessments and the amount they
683 have previously paid. On or before August thirty-first, the Insurance
684 Commissioner and the Healthcare Advocate, after receiving any
685 objections to such statements, shall make such adjustments which in
686 their opinion may be indicated, and shall render an adjusted
687 assessment, if any, to the affected companies. Any such domestic
688 insurance company or other domestic entity may pay to the Insurance

689 Commissioner the entire assessment required under this subsection in
690 one payment when the first installment of such assessment is due.

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

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

700 [(2) (A) All requests for external review or expedited external review
701 shall be accompanied by a filing fee of twenty-five dollars, except that
702 no covered person or covered person's authorized representative shall
703 pay more than seventy-five dollars in a calendar year for such covered
704 person. Any filing fee paid by a covered person's authorized
705 representative shall be deemed to have been paid by the covered person.
706 If the commissioner finds that the covered person is indigent or unable
707 to pay the filing fee, the commissioner shall waive such fee. Any such
708 fees shall be deposited in the Insurance Fund established under section
709 38a-52a.

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

715 [(3)] (2) The health carrier that issued the adverse determination or
716 the final adverse determination that is the subject of the external review
717 request or the expedited external review request shall pay the
718 independent review organization for the cost of conducting the review.

719 [(4)] (3) An external review decision, whether such review is a

720 standard external review or an expedited external review, shall be
721 binding on the health carrier or a self-insured governmental plan and
722 the covered person, except to the extent such health carrier or covered
723 person has other remedies available under federal or state law. A
724 covered person or a covered person's authorized representative shall
725 not file a subsequent request for an external review or an expedited
726 external review that involves the same adverse determination or final
727 adverse determination for which the covered person or the covered
728 person's authorized representative already received an external review
729 decision or an expedited external review decision.

730 [(5)] (4) Each health carrier shall maintain written records of external
731 reviews as set forth in section 38a-591h.

732 [(6)] (5) Each independent review organization shall maintain written
733 records as set forth in subsection (e) of section 38a-591m.

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

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

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

750 (2) The written notice shall include:

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

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

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

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

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

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

791 (ii) If the final adverse determination concerns (I) an admission,
792 availability of care, continued stay or health care service for which the
793 covered person received emergency services but has not been
794 discharged from a facility, the covered person or the covered person's
795 authorized representative may file a request for an expedited external
796 review, or (II) a denial of coverage based on a determination that the
797 recommended or requested health care service or treatment is
798 experimental or investigational and the covered person's treating health
799 care professional certifies in writing that such recommended or
800 requested health care service or treatment would be significantly less
801 effective if not promptly initiated, the covered person or the covered
802 person's authorized representative may file a request for an expedited
803 external review;

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

811 (ii) As part of any forms provided under subparagraph (D)(i) of this
812 subdivision, an authorization form or other document approved by the
813 commissioner that complies with the requirements of 45 CFR 164.508,
814 as amended from time to time, by which the covered person shall

815 authorize the health carrier and the covered person's treating health care
816 professional to release, transfer or otherwise divulge, in accordance with
817 sections 38a-975 to 38a-999a, inclusive, the covered person's protected
818 health information including medical records for purposes of
819 conducting an external review or an expedited external review;

820 (E) A statement that the covered person or the covered person's
821 authorized representative may request, free of charge, copies of all
822 documents, communications, information and evidence regarding the
823 adverse determination or the final adverse determination that were not
824 previously provided to the covered person or the covered person's
825 authorized representative.

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

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

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

836 (A) An adverse determination, if:

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

842 (II) The denial of coverage is based on a determination that the
843 recommended or requested health care service or treatment is
844 experimental or investigational and the covered person's treating health

845 care professional certifies in writing that such recommended or
846 requested health care service or treatment would be significantly less
847 effective if not promptly initiated; and

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

851 (B) A final adverse determination if:

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

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

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

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

873 (e) (1) Not later than one hundred twenty calendar days after a
874 covered person or a covered person's authorized representative receives

875 a notice of an adverse determination or a final adverse determination,
876 the covered person or the covered person's authorized representative
877 may file a request for an external review or an expedited external review
878 with the commissioner in accordance with this section.

879 (2) (A) Not later than one business day after the commissioner
880 receives a request that is complete, the commissioner shall: [send]

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

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

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

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

904 (B) The health care service that is the subject of the adverse
905 determination or the final adverse determination is a covered service

906 under the covered person's health benefit plan but for the health
907 carrier's determination that the health care service is not covered
908 because [it] the health care service does not meet the health carrier's
909 requirements for medical necessity, appropriateness, health care setting,
910 level of care or effectiveness;

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

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

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

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

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

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

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

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

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

933 (II) Is a licensed, board certified or board eligible health care

934 professional qualified to practice in the area of medicine appropriate to
935 treat the covered person's condition and has certified in writing that
936 scientifically valid studies using accepted protocols demonstrate that
937 the health care service or treatment requested by the covered person that
938 is the subject of the adverse determination or the final adverse
939 determination is likely to be more beneficial to the covered person than
940 any available standard health care services or treatments;

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

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

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

959 (B) If the external review or the expedited external review is accepted,
960 the health carrier shall notify the commissioner, the covered person and,
961 if applicable, the covered person's authorized representative in writing
962 of the request's eligibility and acceptance for external review or
963 expedited external review. For an external review, the health carrier
964 shall include in such notice (i) a statement that the covered person or the
965 covered person's authorized representative may submit, not later than

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

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

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

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

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

990 [(D)] (E) Notwithstanding a health carrier's initial determination that
991 a request for an external review or an expedited external review is
992 ineligible for review, the commissioner may determine, pursuant to the
993 terms of the covered person's health benefit plan, that such request is
994 eligible for such review and assign an independent review organization
995 to conduct such review. Any such review shall be conducted in
996 accordance with this section.

997 [(f) (1) Whenever the commissioner is notified pursuant to
998 subparagraph (A) of subdivision (4) of subsection (e) of this section that
999 a request is eligible for external review or expedited external review, the
1000 commissioner shall, not later than one business day after receiving such
1001 notice for an external review or one calendar day after receiving such
1002 notice for an expedited external review:

1003 (A) Assign an independent review organization from the list of
1004 approved independent review organizations compiled and maintained
1005 by the commissioner pursuant to section 38a-591l to conduct the review
1006 and notify the health carrier of the name of the assigned independent
1007 review organization. Such assignment shall be done on a random basis
1008 among those approved independent review organizations qualified to
1009 conduct the particular review based on the nature of the health care
1010 service that is the subject of the adverse determination or the final
1011 adverse determination and other circumstances, including conflict of
1012 interest concerns as set forth in section 38a-591m; and

1013 (B) Notify the covered person and, if applicable, the covered person's
1014 authorized representative in writing of the request's eligibility and
1015 acceptance for external review or expedited external review. For an
1016 external review, the commissioner shall include in such notice (i) a
1017 statement that the covered person or the covered person's authorized
1018 representative may submit, not later than five business days after the
1019 covered person or the covered person's authorized representative, as
1020 applicable, received such notice, additional information in writing to the
1021 assigned independent review organization that such organization shall
1022 consider when conducting the external review, and (ii) where and how
1023 such additional information is to be submitted. If additional information
1024 is submitted later than five business days after the covered person or the
1025 covered person's authorized representative, as applicable, received such
1026 notice, the independent review organization may, but shall not be
1027 required to, accept and consider such additional information.]

1028 [(2)] (f) (1) Not later than five business days for an external review or
1029 one calendar day for an expedited external review, after the health

1030 carrier [receives notice of the name of the assigned independent review
1031 organization from the commissioner] accepts the external review or
1032 expedited external review, the health carrier or its designee utilization
1033 review company shall provide to the assigned independent review
1034 organization the documents and any information such health carrier or
1035 utilization review company considered in making the adverse
1036 determination or the final adverse determination.

1037 [(3)] (2) The failure of the health carrier or its designee utilization
1038 review company to provide the documents and information within the
1039 time specified in subdivision [(2)] (1) of this subsection shall not delay
1040 the conducting of the review.

1041 [(4)] (3) (A) If the health carrier or its designee utilization review
1042 company fails to provide the documents and information within the
1043 time period specified in subdivision [(2)] (1) of this subsection, the
1044 independent review organization may terminate the review and make
1045 a decision to reverse the adverse determination or the final adverse
1046 determination.

1047 (B) Not later than one business day after terminating the review and
1048 making the decision to reverse the adverse determination or the final
1049 adverse determination, the independent review organization shall
1050 notify the commissioner, the health carrier, the covered person and, if
1051 applicable, the covered person's authorized representative in writing of
1052 such decision.

1053 (g) (1) The assigned independent review organization shall review all
1054 the information and documents received pursuant to subsection (f) of
1055 this section. In reaching a decision, the independent review organization
1056 shall not be bound by any decisions or conclusions reached during the
1057 health carrier's utilization review process.

1058 (2) Not later than one business day after receiving any information
1059 submitted by the covered person or the covered person's authorized
1060 representative pursuant to subparagraph (B) of subdivision [(1)] (4) of
1061 subsection [(f)] (e) of this section, the independent review organization

1062 shall forward such information to the health carrier.

1063 (3) (A) Upon the receipt of any information forwarded pursuant to
1064 subdivision (2) of this subsection, the health carrier may reconsider its
1065 adverse determination or the final adverse determination that is the
1066 subject of the review. Such reconsideration shall not delay or terminate
1067 the review.

1068 (B) The independent review organization shall terminate the review
1069 if the health carrier decides, upon completion of its reconsideration and
1070 notice to such organization as provided in subparagraph (C) of this
1071 subdivision, to reverse its adverse determination or its final adverse
1072 determination and provide coverage or payment for the health care
1073 service or treatment that is the subject of the adverse determination or
1074 the final adverse determination.

1075 (C) Not later than one business day after making the decision to
1076 reverse its adverse determination or its final adverse determination, the
1077 health carrier shall notify the commissioner, the assigned independent
1078 review organization, the covered person and, if applicable, the covered
1079 person's authorized representative in writing of such decision.

1080 (h) In addition to the documents and information received pursuant
1081 to subsection (f) of this section, the independent review organization
1082 shall consider, to the extent the documents or information are available
1083 and the independent review organization considers them appropriate,
1084 the following in reaching a decision:

1085 (1) The covered person's medical records;

1086 (2) The attending health care professional's recommendation;

1087 (3) Consulting reports from appropriate health care professionals and
1088 other documents submitted by the health carrier, the covered person,
1089 the covered person's authorized representative or the covered person's
1090 treating health care professional;

1091 (4) The terms of coverage under the covered person's health benefit

1092 plan to ensure that the independent review organization's decision is
1093 not contrary to the terms of coverage under such health benefit plan;

1094 (5) The most appropriate practice guidelines, which shall include
1095 applicable evidence-based standards and may include any other
1096 practice guidelines developed by the federal government, national or
1097 professional medical societies, medical boards or medical associations;

1098 (6) Any applicable clinical review criteria developed and used by the
1099 health carrier or its designee utilization review company; and

1100 (7) The opinion or opinions of the independent review organization's
1101 clinical peer or peers who conducted the review after considering
1102 subdivisions (1) to (6), inclusive, of this subsection.

1103 (i) (1) The independent review organization shall notify the
1104 commissioner, the health carrier, the covered person and, if applicable,
1105 the covered person's authorized representative in writing of its decision
1106 to uphold, reverse or revise the adverse determination or the final
1107 adverse determination, not later than:

1108 (A) For external reviews, forty-five calendar days after such
1109 organization receives the assignment from the commissioner to conduct
1110 such review;

1111 (B) For external reviews involving a determination that the
1112 recommended or requested health care service or treatment is
1113 experimental or investigational, twenty calendar days after such
1114 organization receives the assignment from the commissioner to conduct
1115 such review;

1116 (C) For expedited external reviews, except as specified under
1117 subparagraph (D) of this subdivision, as expeditiously as the covered
1118 person's medical condition requires, but not later than forty-eight hours
1119 after such organization receives the assignment from the commissioner
1120 to conduct such review or seventy-two hours after such organization
1121 receives such assignment if any portion of such forty-eight-hour period

1122 falls on a weekend;

1123 (D) For expedited external reviews involving a health care service or
1124 course of treatment specified under subparagraph (B) or (C) of
1125 subdivision (38) of section 38a-591a, as expeditiously as the covered
1126 person's medical condition requires, but not later than twenty-four
1127 hours after such organization receives the assignment from the
1128 commissioner to conduct such review; and

1129 (E) For expedited external reviews involving a determination that the
1130 recommended or requested health care service or treatment is
1131 experimental or investigational, as expeditiously as the covered person's
1132 medical condition requires, but not later than five calendar days after
1133 such organization receives the assignment from the commissioner to
1134 conduct such review.

1135 (2) Such notice shall include:

1136 (A) A general description of the reason for the request for the review;

1137 (B) The date the independent review organization received the
1138 assignment from the commissioner to conduct the review;

1139 (C) The date the review was conducted;

1140 (D) The date the organization made its decision;

1141 (E) The principal reason or reasons for its decision, including what
1142 applicable evidence-based standards, if any, were used as a basis for its
1143 decision;

1144 (F) The rationale for the organization's decision;

1145 (G) Reference to the evidence or documentation, including any
1146 evidence-based standards, considered by the organization in reaching
1147 its decision; and

1148 (H) For a review involving a determination that the recommended or
1149 requested health care service or treatment is experimental or

1150 investigational:

1151 (i) A description of the covered person's medical condition;

1152 (ii) A description of the indicators relevant to determining whether
 1153 there is sufficient evidence to demonstrate that (I) the recommended or
 1154 requested health care service or treatment is likely to be more beneficial
 1155 to the covered person than any available standard health care services
 1156 or treatments, and (II) the adverse risks of the recommended or
 1157 requested health care service or treatment would not be substantially
 1158 increased over those of available standard health care services or
 1159 treatments;

1160 (iii) A description and analysis of any medical or scientific evidence
 1161 considered in reaching the opinion;

1162 (iv) A description and analysis of any evidence-based standard; and

1163 (v) Information on whether the clinical peer's rationale for the
 1164 opinion is based on the documents and information set forth in
 1165 subsection (f) of this section.

1166 (3) Upon the receipt of a notice of the independent review
 1167 organization's decision to reverse or revise an adverse determination or
 1168 a final adverse determination, the health carrier shall immediately
 1169 approve the coverage that was the subject of the adverse determination
 1170 or the final adverse determination.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2021</i>	19a-7p(b) and (c)
Sec. 2	<i>from passage</i>	38a-12
Sec. 3	<i>October 1, 2021</i>	38a-38(b) to (g)
Sec. 4	<i>July 1, 2021</i>	38a-48(g)
Sec. 5	<i>October 1, 2021</i>	38a-591g

Statement of Purpose:

To: (1) Modify reporting requirements, and impose a late filing fee and penalty, concerning the public health fee; (2) eliminate an annual report from the Insurance Commissioner to the joint standing committee of the General Assembly having cognizance of matters relating to insurance concerning (A) fires and explosions caused by arson, (B) the workers' compensation fraud unit within the office of the Chief State's Attorney, (C) motor vehicle insurance fraud, and (D) health insurance fraud; (3) modify the Insurance Data Security Law; (4) modify the payment schedule for assessments against domestic insurance companies and other domestic entities; and (5) modify the procedures governing external and expedited external reviews of adverse determinations and final adverse determinations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]