Senate

General Assembly

File No. 385

January Session, 2023

Substitute Senate Bill No. 1039

Senate, April 3, 2023

The Committee on Insurance and Real Estate reported through SEN. CABRERA of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDATIONS REGARDING FINANCIAL REGULATION, LIFE INSURANCE AND INSURANCE LICENSING REQUIREMENTS AND TECHNICAL CORRECTIONS TO THE LIFE AND HEALTH INSURANCE STATUTES.

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

Section 1. Section 38a-11 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, two hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, fifty dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, two hundred twenty dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand three hundred fifty dollars; (4) for filing any additional paper required by law, thirty dollars; (5) for each certificate of valuation,

organization, reciprocity or compliance, forty dollars; (6) for each certified copy of a license to a company, forty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, forty dollars; (8) for amending a certificate of authority, two hundred dollars; (9) for each license issued to a rating organization, two hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of fifty dollars for each initial application for a license made pursuant to section 38a-769, as amended by this act; (11) with respect to insurance agents' appointments: (A) A filing fee of fifty dollars for each request for any agent appointment, except that no filing fee shall be payable for a request for agent appointment by an insurance company domiciled in a state or foreign country which does not require any filing fee for a request for agent appointment for a Connecticut insurance company; (B) a fee of one hundred dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of eighty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that (i) no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company, and (ii) the fee shall be twenty dollars for each appointment issued or continued to an agent of an insurance company domiciled in a state or foreign country with a premium tax rate below Connecticut's premium tax rate; (12) with respect to insurance producers: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued; (C) a fee of eighty dollars per year, or any portion thereof, for each license renewed; and (D) a fee of eighty dollars for any license renewed under the transitional process established in section 38a-784; (13) with respect to public adjusters: (A) An examination fee of fifteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of fifteen dollars to the

commissioner for each examination taken by an applicant; and (B) a fee of two hundred fifty dollars for each license issued or renewed; (14) with respect to casualty claims adjusters: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of eighty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of eighty dollars to the commissioner for each examination taken by an applicant; (B) a fee of eighty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of twenty-six dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty-six dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred fifty dollars for each license issued; and (C) a fee of two hundred fifty dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of twenty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of twenty dollars to the commissioner for each examination taken by an applicant; and (B) a fee of six hundred twenty-five dollars for each license issued or renewed; (18) with respect to fraternal agents, a fee of eighty dollars for each license issued or renewed; (19) a fee of twenty-six dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to

domestic and foreign benefit societies shall pay: (A) For service of process, fifty dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, fifteen dollars; (C) for filing an annual statement or report, twenty dollars; and (D) for filing any additional paper required by law, fifteen dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, fifteen dollars; (B) for each certified copy of permit, fifteen dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, fifteen dollars; (22) with respect to reinsurance intermediaries, a fee of six hundred twenty-five dollars for each license issued or renewed; (23) with respect to life settlement providers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (24) with respect to life settlement brokers: (A) A filing fee of twenty-six dollars for each initial application for a license made pursuant to section 38a-465a; and (B) a fee of forty dollars for each license issued or renewed; (25) with respect to preferred provider networks, a fee of two thousand seven hundred fifty dollars for each license issued or renewed; (26) with respect to rental companies, as defined in section 38a-799, a fee of eighty dollars for each permit issued or renewed; (27) with respect to medical discount plan organizations licensed under section 38a-479rr, a fee of six hundred twenty-five dollars for each license issued or renewed; (28) with respect to pharmacy benefits managers, an application fee of one hundred dollars for each registration issued or renewed; (29) with respect to captive insurance companies, as defined in section 38a-91aa, a fee of three hundred seventy-five dollars for each license issued or renewed; (30) with respect to each duplicate license issued a fee of fifty dollars for each license issued; (31) with respect to surety bail bond agents, as defined in section 38a-660, (A) a filing fee of one hundred fifty dollars for each initial application for a license, and (B) a fee of one hundred dollars for each license issued or renewed; (32) with respect to third-party administrators, as defined in section 38a-720, (A) a fee of five hundred dollars for each license issued, and (B) a fee of four hundred fifty dollars for each license renewed; (33) with respect to portable

electronics insurance licenses under section 38a-397, (A) a filing fee of one hundred dollars for each initial application for a license, (B) a fee of five hundred dollars for each license issued, and (C) a fee of four hundred fifty dollars for each license renewed; **[**and**]** (34) with respect to limited lines travel insurance producer licenses under section 38a-398, (A) a filing fee of one hundred dollars for each initial application for a license, (B) a fee of six hundred fifty dollars for each license issued, and (C) a fee of six hundred fifty dollars for each license renewed; (35) with respect to certified reinsurers, as certified by the commissioner pursuant to section 38a-88-4a of the regulations of Connecticut state agencies, a fee of two thousand dollars for each certificate issued and renewed; and (36) with respect to reciprocal jurisdiction reinsurers, as defined in section 38a-88-4b of the regulations of Connecticut state agencies, a fee of two thousand dollars for each certificate issued and renewed.

(b) If any state imposes fees upon domestic fraternal benefit societies greater than are fixed by this section or sections 38a-595 to 38a-626, inclusive, 38a-631 to 38a-640, inclusive, or 38a-800, the commissioner shall collect from each fraternal benefit society incorporated by or organized under the laws of such other state and admitted to transact business in this state, the same fees as are imposed upon similar domestic societies and organizations by such other state. The expense of any examination or inquiry made outside the state shall be borne by the society so examined.

(c) Each unauthorized insurer declared to be an eligible surplus lines insurer shall pay to the Insurance Commissioner, on or before May first of each year, an annual fee of one hundred twenty-six dollars in order to remain on the list of eligible surplus lines insurers.

(d) For service of process on the commissioner, the commissioner shall demand and receive a fee of fifty dollars for each person or insurer to be served. The commissioner shall also collect, for each hospital or ambulance lien filed, fifty dollars, and for each small claims notice filed, fifteen dollars, each of which shall be paid by the plaintiff at the time of service, the same to be recovered by him as part of the taxable costs if he

prevails in the suit.

(e) Each insurance company depositing any security with the Treasurer pursuant to section 38a-83 shall pay to the commissioner three hundred fifteen dollars, annually. In case of an examination or appraisal made outside the office of the Treasurer, and in such case the company in whose behalf such examination or appraisal has been made shall pay to the commissioner two hundred dollars for such examination and the actual traveling expenses of the officer making such examination or appraisal.

(f) Notwithstanding any provision of the general statutes, the commissioner may require that any person required by any provision of this title to pay a fee to the commissioner pay such fee to the commissioner by electronic means. Such person may submit a request to the commissioner for an exception to the electronic fee requirement. The commissioner shall grant such request for an exception, provided the commissioner determines that (1) compliance with the electronic fee requirement is impractical or reasonably causes such person to suffer undue hardship, or (2) good cause exists to grant such requested exception.

Sec. 2. Section 38a-769 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Any person, partnership, association or corporation that is resident in this state**,** **[**or has its principal place of business in this state,**]** or a nonresident of this state who is not licensed in any other state that offers the type of license sought in this state and maintains a principal place of business in this state, desiring to act within this state as a public adjuster, casualty adjuster, motor vehicle physical damage appraiser, certified insurance consultant, surplus lines broker or desiring to engage in any insurance-related occupation for which a license is deemed necessary by the commissioner, other than an occupation as an insurance producer, shall make a written application to the commissioner for a resident license. Any other person, partnership, association or corporation desiring to so act or to engage in any

insurance-related occupation for which a license is deemed necessary by the commissioner, other than an occupation as an insurance producer, shall make a written application to the commissioner for a nonresident license. **[**No**]**

(b) Except as provided in subsection (c) of this section, no application for a nonresident license shall be granted unless the applicant holds an equivalent license from any other state. Any application for a resident or nonresident license shall be made for each name or designation under which such business shall be conducted, in such form as the commissioner prescribes, stating the line or lines of insurance for which the applicant desires such license and any other business which the applicant desires also to transact. All initial applications shall be accompanied by a nonrefundable filing fee specified in section 38a-11. The commissioner shall cause to be made such inquiry and examination as to the qualifications of each such applicant as the commissioner deems necessary.

(c) Any person, partnership, association or corporation residing in a state that does not offer the type of license sought by such person, partnership, association or corporation in this state may make a written application to the commissioner for a nonresident license and designate this state as such person's, association's or corporation's home state.

[(b)**]** (d) Each application for a license shall be signed by: The applicant, if the application is for an individual; a licensed officer, if the application is for a corporation; a licensed partner, if the application is for a partnership; and a licensed principal, if the application is for any other applicant.

[(c)**]** (e) Each applicant for a license shall furnish satisfactory evidence to the commissioner that the applicant is a person of good moral character and that the applicant is financially responsible. In order to determine the trustworthiness and competency of an applicant the commissioner shall subject the applicant to personal written examination as to the applicant's competency to act as a licensee for each line of insurance for which the applicant desires to be licensed. The

commissioner may, at the commissioner's discretion, designate an independent testing service to prepare and administer such examination, provided any examination fees charged by such service shall be paid by the applicant. The commissioner shall collect the appropriate examination fee as specified in section 38a-11, as amended by this act, which shall entitle the applicant to take the examination for the license desired, except that when a testing service is used, the testing service shall pay such fee to the commissioner for each examination taken by an applicant. In either case, each such examination shall be as the commissioner prescribes and shall be of sufficient scope to test the applicant's knowledge of insurance, the duties and responsibilities of a licensee and the laws of this state applicable to insurance. The commissioner may require a waiting period not exceeding six months, before reexamining any applicant who has failed to pass any such examination.

[(d)**]** (f) Upon finding that an applicant meets the licensing requirements of this title and is in all respects properly qualified and trustworthy and that the granting of such license is not against the public interest, the commissioner may issue to such applicant the license applied for, in such form as the commissioner may adopt, to act within this state to the extent therein specified.

[(e)**]** (g) The commissioner may adopt regulations, in accordance with chapter 54, concerning the approval of schools offering courses in insurance, the content of such courses and the advertising to the public of the services of these schools.

[(f)**]** (h) To further the enforcement of this section 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.

[(g)**]** (i) A license may, in the discretion of the commissioner, be renewed or continued upon payment of the appropriate fee as specified in section 38a-11, as amended by this act, without the resubmittal of the detailed information required in the original application.

(j) The provisions of subsections (b) to (i), inclusive, of this section shall be applicable to any licensee or applicant for a license, including, but not limited to, such licensee engaged in, or such applicant who seeks to become licensed to engage in, the occupation of insurance producer.

Sec. 3. Section 38a-489 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician, physician assistant or advanced practice registered nurse on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon the policyholder or subscriber for support and maintenance.

(b) Proof of the incapacity and dependency shall be furnished to the insurer, hospital service corporation, medical service corporation or health care center by the policyholder or subscriber within thirty-one days of the child's attainment of the limiting age. The insurer, corporation or health care center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age the insurer, corporation or health care center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

Sec. 4. Subsection (a) of section 38a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469 for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

Sec. 5. Subsection (a) of section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child, stepchild or other dependent child shall terminate not earlier than the policy anniversary date after the date on which the child, stepchild or other dependent child attains the age of twenty-six.

Sec. 6. Subsection (a) of section 38a-508 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide coverage for a child legally placed for adoption with the insured or subscriber who is an adoptive parent or a prospective adoptive parent, even though the adoption has not been finalized, provided the child lives in the household of such insured or subscriber and the child is dependent upon such person for support and maintenance.

Sec. 7. Subsection (a) of section 38a-512b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October*

1, 2023):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide that coverage of a child, stepchild or other dependent child shall terminate not earlier than the policy anniversary date after the date on which the child, stepchild or other dependent child attains the age of twenty-six.

Sec. 8. Subsection (a) of section 38a-515 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state that provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician, physician assistant or advanced practice registered nurse on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon such employee or member for support and maintenance.

Sec. 9. Subsection (a) of section 38a-516 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (11) and (12) of section

38a-469 for a family member of the insured or subscriber shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

Sec. 10. Subsection (a) of section 38a-549 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), **[**(6),**]** (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide coverage for a child legally placed for adoption with an employee or other member of the covered group who is an adoptive parent or a prospective adoptive parent, even though the adoption has not been finalized, provided the child lives in the household of such employee or member and the child is dependent upon such employee or member for support and maintenance.

Sec. 11. Section 38a-509 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2018, shall provide coverage for the medically necessary expenses **[**of**]** for the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. For purposes of this section, "infertility" means the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

(b) Such policy may:

[(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;**]**

[(2)**]** (1) Limit such coverage for ovulation induction to a lifetime maximum benefit of four cycles;

[(3)**]** (2) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of three cycles;

[(4)**]** (3) Limit such coverage for lifetime benefits to a maximum of two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one cycle;

[(5)**]** (4) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful; and

[(6)**]** (5) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility. **[**;**]**

[(7) Limit coverage to individuals who have maintained coverage under such policy for at least twelve months; and

(8) Require disclosure by the individual seeking such coverage to

such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner.**]**

(c) (1) Any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

(d) Any health insurance policy issued pursuant to subsection (c) of this section shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

(e) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.

(f) Except as provided in subsections (c) to (e), inclusive, of this section, no individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2024, may make any distinction or discrimination between persons on the basis of gender identity or expression, sex or age with respect to health insurance coverage for the

medically necessary expenses for the diagnosis and treatment of infertility, except that such policy may consider age as a factor on the basis of a determination of medical necessity, using professional guidelines published by the American Society for Reproductive Medicine, its successor organization or a comparable organization. For purposes of this subsection, "gender identity or expression" has the same meaning as provided in section 1-1n.

Sec. 12. Section 38a-536 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2018, shall provide coverage for the medically necessary expenses **[**of**]** for the diagnosis and treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. For purposes of this section, "infertility" means the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or such treatment is medically necessary.

(b) Such policy may:

[(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;**]**

[(2)**]** (1) Limit such coverage for ovulation induction to a lifetime maximum benefit of four cycles;

[(3)**]** (2) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of three cycles;

[(4)**]** (3) Limit such coverage for lifetime benefits to a maximum of

two cycles, with not more than two embryo implantations per cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one cycle;

[(5)**]** (4) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful; and

[(6)**]** (5) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility. **[**;**]**

[(7) Limit coverage to individuals who have maintained coverage under such policy for at least twelve months; and

(8) Require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner.**]**

(c) (1) Any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious employer a group health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

(d) Any health insurance policy issued pursuant to subsection (c) of this section shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

(e) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.

(f) Except as provided in subsections (c) to (e), inclusive, of this section, no group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2024, may make any distinction or discrimination between persons on the basis of gender identity or expression, sex or age with respect to health insurance coverage for the medically necessary expenses for the diagnosis and treatment of infertility, except that such policy may consider age as a factor on the basis of a determination of medical necessity, using professional guidelines published by the American Society for Reproductive Medicine, its successor organization or a comparable organization. For purposes of this subsection, "gender identity or expression" has the same meaning as provided in section 1-1n.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2023*	38a-11

Sec. 2	*October 1, 2023*	38a-769
Sec. 3	*October 1, 2023*	38a-489
Sec. 4	*October 1, 2023*	38a-490(a)
Sec. 5	*October 1, 2023*	38a-497(a)
Sec. 6	*October 1, 2023*	38a-508(a)
Sec. 7	*October 1, 2023*	38a-512b(a)
Sec. 8	*October 1, 2023*	38a-515(a)
Sec. 9	*October 1, 2023*	38a-516(a)
Sec. 10	*October 1, 2023*	38a-549(a)
Sec. 11	*October 1, 2023*	38a-509
Sec. 12	*October 1, 2023*	38a-536

Statement of Legislative Commissioners:
In Section 1(f), "to" before "pay such fee" was deleted for clarity.

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 24 $	FY 25 $
Insurance Dept.	GF - Revenue Gain	104,000 - 154,000	104,000 - 154,000

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill includes various provisions regarding insurance which result in the impacts discussed by section below.

Section 1 results in an annual revenue gain to the General Fund beginning in FY 24 of approximately $104,000, by requiring certified reinsurers and reciprocal jurisdiction reinsurers to pay the Insurance Department (DOI) $2,000 for each certificate issued and annually renewed. Currently, there are approximately 17 certified reinsurers and 35 reciprocal jurisdiction reinsurers that would begin paying the fee in FY 24.

The provision in **Section 1** that authorizes DOI to require its fees be paid electronically is not anticipated to result in a fiscal impact because most payments are already made electronically.

Section 2 allows a non-resident person or entity to get a nonresident state insurance license in Connecticut in certain circumstances, which results in a potential General Fund revenue gain beginning in FY 24, which is anticipated to be less than $50,000 annually. The revenue gain depends on: (1) the number of non-resident persons and entities that

apply to DOI and become licensed, and (2) the specific application, licensing, and renewal fees that correspond to those application and license types.

Sections 3-10 make technical corrections to health insurance statutes that do not result in a fiscal impact. The bill removes requirements that health insurers and HMOs include dependent coverage in "accident-only" policies. That type of policy typically only pays a benefit when the insured sustains injuries or dies due to an accident.

Sections 11 and 12 codify the removal of certain limitations on medically necessary infertility diagnosis and treatment coverage previously issued by the Department of Insurance, resulting in no anticipated fiscal impact to the state or municipal health plans.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the number of certified reinsurers, reciprocal jurisdiction reinsurers, and non-resident persons and entities paying fees to DOI.

OLR Bill Analysis

sSB 1039

AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDATIONS REGARDING FINANCIAL REGULATION, LIFE INSURANCE AND INSURANCE LICENSING REQUIREMENTS AND TECHNICAL CORRECTIONS TO THE LIFE AND HEALTH INSURANCE STATUTES.

SUMMARY

This bill prohibits certain health insurance policies, beginning January 1, 2024, from discriminating between people on the basis of gender identity or expression, sex, or age with respect to health insurance coverage for medically necessary infertility diagnosis and treatment. It also revises the allowed parameters for a policy to cover infertility-related expenses to conform to the federal Affordable Care Act (§§ 11 & 12).

This bill also makes a number of unrelated changes to the insurance statutes. Specifically, the bill does the following:

1. authorizes the insurance commissioner to require people and entities required to pay fees to the Insurance Department to do so electronically and establishes a waiver process for the requirement (§ 1);

2. requires certified reinsurers and reciprocal jurisdiction reinsurers to pay the Insurance Department a fee of $2,000 for each regulatory certificate issued and renewed (§ 1);

3. allows a non-resident person or entity to get a nonresident state license here and designate Connecticut as their home state if their resident state does not offer the same or equivalent license (§ 2);

4. makes explicit that certain provisions of the general licensing statute apply to any licensee or license applicant, including an insurance producer licensee or applicant (§ 2); and

5. makes technical corrections to the applicability of the health insurance statutes requiring dependent coverage, specifically to remove applicability to accident-only policies, which do not cover a dependent's illness-related expenses (§§ 3-10).

EFFECTIVE DATE: October 1, 2023

§ 1 — STATUTORY INSURANCE FEES

Electronic Payment

The bill authorizes the insurance commissioner to require people and entities required by state law to pay fees to the Insurance Department to pay them electronically. However, the commissioner must waive this requirement for any person or entity that requests it if he determines that (1) compliance is impractical or causes undue hardship or (2) good cause otherwise exists.

Reinsurer Fees

The bill adds two fees to the list of statutory insurance fees. Specifically, it requires certified reinsurers and reciprocal jurisdiction reinsurers to pay the Insurance Department $2,000 for each certificate issued and renewed. State law and regulations require these reinsurers to apply to the department for certification (CGS § 38a-85a and Conn. Agencies Regs., § 38a-88-4a & -4b).

§ 2 — INSURANCE LICENSURE REQUIREMENTS

Non-Resident Licenses

The bill specifies requirements for people or entities who are eligible to get certain non-resident licenses from the Insurance Department. It allows a non-resident person or entity to apply for and get a nonresident state license here and designate Connecticut as their home state if their resident state does not offer the same or equivalent resident license and they maintain a principal place of business here.

This applies to the following licenses: public adjuster, casualty adjuster, motor vehicle physical damage appraiser, certified insurance consultant, surplus lines broker, or any insurance-related occupation for which a license is deemed necessary by the commissioner, other than an insurance producer.

Insurance Producers

In 2014, a Connecticut court ruled that because the legislature adopted specific insurance producer requirements in 2001 (PA 01-113), the general licensing statute does not apply to insurance producers (*Lagueux* v. *Leonardi*, 148 Conn. App. 234 (2014)). The bill makes explicit that certain provisions of the general insurance licensing statute (i.e., CGS § 38a-769(b)-(i)) apply to any licensee or license applicant, including an insurance producer licensee or applicant. By law, this includes requirements that the applicant prove to the commissioner he or she is financially responsible and of sound moral character.

§§ 11 & 12 — MANDATED HEALTH INSURANCE COVERAGE FOR INFERTILITY DIAGNOSIS AND TREATMENT

Changes to Conform to Federal Law

By law, certain individual and group health insurance policies must cover the medically necessary costs of diagnosing and treating infertility. Current law allows insurers to impose certain limits on the coverage (e.g., number of attempts, among other things). The bill eliminates the ability of a policy to:

1. limit infertility coverage to those (a) under age 40 and (b) who had coverage under the policy for at least 12 months and

2. require an insured to disclose any previous infertility treatment covered under a different policy.

These changes generally conform the coverage provision to the federal Affordable Care Act and codify the Insurance Department's Bulletin HC-104 (2015).

The law, unchanged by the act, allows religious employers and

individuals to exclude infertility coverage from their policies if it is contrary to their religious tenets.

By law, "infertility" means being unable to conceive or produce conception or sustain a successful pregnancy during a one-year period or the treatment is medically necessary.

Nondiscrimination Provision

The bill prohibits certain individual and group health insurance policies from discriminating between people on the basis of gender identity or expression, sex, or age with respect to health insurance coverage for medically necessary infertility diagnosis and treatment. However, a policy may consider age as a factor when determining medical necessity, using guidelines from the American Society for Reproductive Medicine or a comparable organization.

Under the bill, this nondiscrimination provision does not apply when a religious employer or individual excludes infertility coverage from a policy due to their religious tenets.

The law defines "gender identity or expression" as a person's gender-related identity, appearance, or behavior, whether or not it differs from that traditionally associated with the person's physiology or assigned sex at birth. The definition specifies that gender-related identity can be shown by providing evidence in various ways, including (1) medical history; (2) care or treatment of the gender-related identity; (3) consistent and uniform assertion of the identity; or (4) any other evidence that the identity is sincerely held, part of a person's core identity, or that the person is not asserting the identity for an improper purpose.

Applicability

The bill applies the federal law conforming changes to policies delivered, issued, renewed, amended, or continued in Connecticut on and after October 1, 2023, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. It

applies the nondiscrimination provision to these policies that are delivered, issued, renewed, amended, or continued in Connecticut on and after January 1, 2024.

Because of the federal Employee Retirement Income Security Act, state insurance benefit mandates do not apply to self-insured benefit plans.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11 Nay 1 (03/16/2023)