



House of Representatives

File No. 827

General Assembly

January Session, 2015

(Reprint of File No. 205)

House Bill No. 6868
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 14, 2015

***AN ACT CONCERNING THE CONNECTICUT INSURANCE
GUARANTY ASSOCIATIONS.***

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

1 Section 1. Subdivisions (5) and (6) of section 38a-838 of the general
2 statutes are repealed and the following is substituted in lieu thereof
3 (*Effective October 1, 2015*):

4 (5) (A) "Covered claim" means an unpaid claim, including, but not
5 limited to, one for unearned premiums, [which] that arises out of and
6 is within the coverage and subject to the applicable limits of an
7 insurance policy to which sections 38a-836 to 38a-853, inclusive, apply,
8 [issued by an insurer,] if such insurer becomes an insolvent insurer
9 [after October 1, 1971, and (A)] or such claim was assumed as a direct
10 obligation by an insurer that becomes an insolvent insurer, where such
11 obligation was assumed through a merger or an acquisition, pursuant
12 to an acquisition of assets and assumption of liabilities or pursuant to
13 an assumption reinsurance transaction, and (i) the claimant or insured
14 is a resident of this state at the time of the insured event, [; or (B)] or (ii)

15 the claim is a first party claim for damage to property with a
16 permanent location in this state, [, provided the term "covered claim"
17 shall] For the purposes of this subparagraph, the residence of a
18 claimant or an insured that is not an individual shall be the state in
19 which such claimant's or insured's principal place of business is
20 located at the time of the insured event.

21 (B) "Covered claim" does not include (i) any claim by or for the
22 benefit of any reinsurer, insurer, insurance pool [,] or underwriting
23 association, as subrogation recoveries or otherwise, [,] provided [that]
24 a claim for any such amount, asserted against a person insured under a
25 policy issued by an insurer [which] that has become an insolvent
26 insurer, [which] that, if it were not a claim by or for the benefit of a
27 reinsurer, insurer, insurance pool or underwriting association, would
28 be a "covered claim", may be filed directly with the receiver of the
29 insolvent insurer but in no event shall any such claim be asserted
30 against the insured of such insolvent insurer, (ii) any claim by or on
31 behalf of an individual who is neither a citizen of the United States nor
32 an alien legally resident in the United States at the time of the insured
33 event, or an entity other than an individual whose principal place of
34 business is not in the United States at the time of the insured event,
35 and it arises out of an accident, occurrence, offense, act, error or
36 omission that takes place outside of the United States, or a loss to
37 property normally located outside of the United States or, if a workers'
38 compensation claim, it arises out of employment outside of the United
39 States, (iii) any claim by or on behalf of a person who is not a resident
40 of this state, other than a claim for compensation or any other benefit
41 [which] that arises out of and is within the coverage of a workers'
42 compensation policy, against an insured whose net worth at the time
43 the policy was issued or at any time thereafter exceeded twenty-five
44 million dollars, provided [that] an insured's net worth for purposes of
45 this section and section 38a-844 shall be deemed to include the
46 aggregate net worth of the insured and all of its subsidiaries as
47 calculated on a consolidated basis, (iv) any claim by or on behalf of an
48 affiliate of the insolvent insurer at the time the policy was issued or at

49 the time of the insured event, [or] (v) any claim arising out of a policy
50 issued by an insurer [which] that was not licensed to transact
51 insurance in this state [either] at the time the policy was issued, when
52 it assumed the obligation for the covered claim or when the insured
53 event occurred, (vi) any amount due under any policy originally
54 issued by a surplus lines carrier, risk retention group, self-insurer or
55 group self-insurer, (vii) any obligation assumed by an insolvent
56 insurer after the commencement of any delinquency proceeding, as
57 defined in section 38a-905, involving the insolvent insurer or the
58 original insurer, unless it would have been a covered claim absent such
59 assumption, or (viii) any obligation assumed by an insolvent insurer in
60 a transaction in which the original insurer remains separately liable;

61 (6) "Insolvent insurer" means an insurer (A) (i) licensed to transact
62 insurance in this state [either] at the time the policy was issued, when
63 it assumed the obligation for the covered claim or when the insured
64 event occurred, and (ii) [determined to be insolvent] against which a
65 final order of liquidation with a finding of insolvency has been entered
66 by a court of competent jurisdiction in the insurer's state of domicile;
67 (B) [which] that is (i) the legal successor of an insurer that was licensed
68 to transact insurance in this state either at the time the policy was
69 issued or when the insured event occurred, by reason of a merger,
70 provided such merger is approved by an insurance regulator having
71 jurisdiction over such merger, and (ii) [determined to be insolvent]
72 against which a final order of liquidation with a finding of insolvency
73 has been entered by a court of competent jurisdiction in the insurer's
74 state of domicile; or (C) [which] that (i) succeeds to the policy
75 obligations of an insurer that was licensed to transact insurance in this
76 state either at the time the policy was issued or when the insured event
77 occurred, by reason of a division whereby policies issued by such
78 licensed insurer are transferred to an insurer, [and (ii) is determined to
79 be insolvent by a court of competent jurisdiction,] provided such
80 division is approved (I) in a jurisdiction that allows such division, and
81 (II) by an insurance regulator having jurisdiction over such division,
82 and (ii) against which a final order of liquidation with a finding of

83 insolvency has been entered by a court of competent jurisdiction in the
84 succeeding insurer's state of domicile. "Insolvent insurer" shall not be
85 construed to mean any insurer with respect to which an order, decree,
86 judgment or finding of insolvency, whether permanent or temporary
87 in nature, or order of rehabilitation or conservation has been issued by
88 a court of competent jurisdiction prior to October 1, 1971;

89 Sec. 2. Subsection (a) of section 38a-841 of the general statutes is
90 repealed and the following is substituted in lieu thereof (*Effective*
91 *October 1, 2015*):

92 (a) Said association shall:

93 (1) Be obligated to the extent of the covered claims existing prior to
94 the determination of insolvency or the entry of a final order of
95 liquidation with a finding of insolvency, as applicable, and arising
96 within thirty days after the determination of insolvency or the entry of
97 such order, or before the policy expiration date if less than thirty days
98 after the determination or the entry of such order, or before the insured
99 replaces the policy or causes its cancellation [, if he] if the insured does
100 so within thirty days [of] after such determination or entry of such
101 order, provided such obligation shall be limited as follows: (A) With
102 respect to covered claims for unearned premiums, to one-half of the
103 unearned premium on any policy, subject to a maximum of two
104 thousand dollars per policy; (B) with respect to covered claims other
105 than for unearned premiums, such obligation shall include only that
106 amount of each such claim [which] that is in excess of one hundred
107 dollars and is less than (i) three hundred thousand dollars for claims
108 arising under policies of insurers determined to be insolvent prior to
109 October 1, 2007, [and] (ii) four hundred thousand dollars for claims
110 arising under policies of insurers determined to be insolvent on or
111 after October 1, 2007, [except that said] and prior to October 1, 2015,
112 and (iii) five hundred thousand dollars for claims arising under
113 policies of insurers against which a final order of liquidation with a
114 finding of insolvency has been entered by a court of competent
115 jurisdiction in the insurer's state of domicile on or after October 1, 2015.

116 Said association shall pay the full amount of any such claim arising out
117 of a workers' compensation policy, provided in no event shall said
118 association be obligated [(i)] (I) to any claimant in an amount in excess
119 of the obligation of the insolvent insurer under the policy form or
120 coverage from which the claim arises, or [(ii)] (II) for any claim filed
121 with the association after the expiration of two years from the date of
122 the declaration of insolvency unless such claim arose out of a workers'
123 compensation policy and was timely filed in accordance with section
124 31-294c;

125 (2) [be] Be deemed the insurer to the extent of its obligations on the
126 covered claims and to such extent shall have all rights, duties, and
127 obligations of the insolvent insurer as if the insurer had not become
128 insolvent;

129 (3) [allocate] Allocate claims paid and expenses incurred among the
130 three accounts, created by section 38a-839, separately, and assess
131 member insurers separately (A) in respect of each such account for
132 such amounts as shall be necessary to pay the obligations of said
133 association under subdivision (1) of this subsection subsequent to an
134 insolvency; (B) the expenses of handling covered claims subsequent to
135 an insolvency; (C) the cost of examinations under section 38a-846; and
136 (D) such other expenses as are authorized by sections 38a-836 to 38a-
137 853, inclusive. The assessments of each member insurer shall be in the
138 proportion that the net direct written premiums of such member
139 insurer for the calendar year preceding the assessment on the kinds of
140 insurance in such account bears to the net direct written premiums of
141 all member insurers for the calendar year preceding the assessment on
142 the kinds of insurance in such account. Each member insurer shall be
143 notified of its assessment not later than thirty days before it is due. No
144 member insurer may be assessed in any year on any account an
145 amount greater than two per cent of that member insurer's net direct
146 written premiums for the calendar year preceding the assessment on
147 the kinds of insurance in said account, provided if, at the time an
148 assessment is levied on the all other insurance account, as defined in
149 subdivision (3) of section 38a-839, the board of directors finds that at

150 least fifty per cent of the total net direct written premiums of a member
151 insurer and all its affiliates, for the year on which such assessment is
152 based, were from policies issued or delivered in Connecticut, on risks
153 located in this state, such member insurer shall be assessed only on
154 such member insurer's net direct written premium that is attributable
155 to the kind of insurance that gives rise to each covered claim. If the
156 maximum assessment, together with the other assets of said
157 association in any account, does not provide in any one year in any
158 account an amount sufficient to make all necessary payments from that
159 account, the funds available may be prorated and the unpaid portion
160 shall be paid as soon thereafter as funds become available. Said
161 association may defer, in whole or in part, the assessment of any
162 member insurer [,] if the assessment would cause the member insurer's
163 financial statement to reflect amounts of capital or surplus less than the
164 minimum amounts required for a certificate of authority by any
165 jurisdiction in which the member insurer is authorized to transact
166 insurance, provided [that] during the period of deferment, no
167 dividends shall be paid to shareholders or policyholders. Deferred
168 assessments shall be paid when such payment will not reduce capital
169 or surplus below the minimum amounts required for a certificate of
170 authority. Such payments shall be refunded to those insurers receiving
171 greater assessments because of such deferment or, at the election of the
172 insurer, be credited against future assessments. Each member insurer
173 serving as a servicing facility may set off against any assessment,
174 authorized payments made on covered claims and expenses incurred
175 in the payment of such claims by such member insurer if they are
176 chargeable to the account in respect of which the assessment is made;

177 (4) [investigate] Investigate claims brought against said association
178 and adjust, compromise, settle, and pay covered claims to the extent of
179 said association's obligations [,] and deny all other claims. The
180 association shall pay claims in any order it deems reasonable
181 including, but not limited to, payment in the order of receipt or by
182 classification. It may review settlements, releases and judgments to
183 which the insolvent insurer or its insureds were parties to determine

184 the extent to which such settlements, releases and judgments may be
185 properly contested;

186 (5) [notify] Notify such persons as the commissioner may direct
187 under subdivision (1) of subsection (b) of section 38a-843, as amended
188 by this act;

189 (6) [handle] Handle claims through its employees or through one or
190 more insurers or other persons designated by said association as
191 servicing facilities, provided such designation of a servicing facility
192 [shall be subject to the approval of] is approved by the commissioner
193 [.] and may be declined by a member insurer;

194 (7) [reimburse] Reimburse each such servicing facility for
195 obligations of said association paid by such facility and for expenses
196 incurred by such facility while handling claims on behalf of said
197 association and shall pay such other expenses of said association as are
198 authorized by sections 38a-836 to 38a-853, inclusive.

199 Sec. 3. Subsections (a) and (b) of section 38a-843 of the general
200 statutes are repealed and the following is substituted in lieu thereof
201 (*Effective October 1, 2015*):

202 (a) The commissioner shall: (1) Notify said association of the
203 existence of an insolvent insurer, and notify the chairman of the
204 Workers' Compensation Commission and the State Treasurer of the
205 existence of an insolvent workers' compensation insurer, not later than
206 three days after [he] the commissioner receives notice of [the
207 determination of] any such insolvency; (2) upon request of the board of
208 directors, provide said association with a statement of the net direct
209 written premiums of each member insurer.

210 (b) The commissioner may: (1) Require that said association notify
211 those persons insured by the insolvent insurer, and any other
212 interested parties, of the [determination] entry of a final order of
213 liquidation with a finding of insolvency and of their rights under
214 sections 38a-836 to 38a-853, inclusive. Such notification shall be by mail

215 sent to their last known address, where available, provided if sufficient
216 information for such notification by mail is not available, notice by
217 publication in a newspaper of general circulation shall be sufficient to
218 satisfy the requirements of this subsection; (2) suspend or revoke, after
219 notice and hearing, the certificate of authority to transact insurance in
220 this state of any member insurer that fails to pay an assessment when
221 due or which fails to comply with said plan of operation. In lieu of
222 such suspension or revocation, the commissioner may levy a fine on
223 any member insurer [which] that fails to pay an assessment when due,
224 provided no such fine shall exceed five per cent of the unpaid
225 assessment per month, and provided no fine shall be less than five
226 hundred dollars per month; (3) revoke the designation of any servicing
227 facility if the commissioner finds claims are being handled
228 unsatisfactorily.

229 Sec. 4. Subsection (f) of section 38a-860 of the general statutes is
230 repealed and the following is substituted in lieu thereof (*Effective*
231 *October 1, 2015*):

232 (f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage
233 to the persons specified in subsections (a) to (d), inclusive, of this
234 section for direct, nongroup life, health or annuity policies or contracts
235 and supplemental contracts to such policies or contracts, for certificates
236 under direct group policies and contracts, and for unallocated annuity
237 contracts issued by member insurers, except as limited by said
238 sections. Annuity contracts and certificates under group annuity
239 contracts include, but are not limited to, guaranteed investment
240 contracts, deposit administration contracts, unallocated funding
241 agreements, allocated funding agreements, structured settlement
242 annuities, annuities issued to or in connection with government
243 lotteries and any immediate or deferred annuity contracts.

244 (2) [Said sections] Sections 38a-858 to 38a-875, inclusive, shall not
245 provide coverage for: (A) Any portion of a policy or contract not
246 guaranteed by the insurer, or under which the risk is borne by the
247 policy or contract holder; (B) any policy or contract of reinsurance,

248 unless assumption certificates have been issued; (C) any portion of a
249 policy or contract to the extent that the rate of interest on which it is
250 based or the interest rate, crediting rate or similar factor determined by
251 use of an index or other external reference stated in the policy or
252 contract employed in calculating returns or changes in value (i)
253 averaged over the period of four years prior to the date on which the
254 member insurer becomes an impaired or insolvent insurer under
255 sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest
256 determined by subtracting two percentage points from Moody's
257 corporate bond yield average averaged for that same four-year period
258 or for such lesser period if the policy or contract was issued less than
259 four years before the member insurer becomes an impaired or
260 insolvent insurer under sections 38a-858 to 38a-875, inclusive,
261 whichever is earlier, [;] and (ii) on and after the date on which the
262 member insurer becomes an impaired or insolvent insurer under
263 sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the
264 rate of interest determined by subtracting three percentage points from
265 Moody's corporate bond yield average as most recently available; (D) a
266 portion of a policy or contract issued to any plan or program of an
267 employer, association or similar entity to provide life, health or
268 annuity benefits to its employees or members to the extent that such
269 plan or program is self-funded or uninsured, including, but not limited
270 to, benefits payable by an employer, association or similar entity under
271 (i) a multiple employer welfare arrangement as defined in Section 514
272 of the federal Employee Retirement Income Security Act of 1974, as
273 amended from time to time, [;] (ii) a minimum premium group
274 insurance plan, [;] or (iii) an administrative services only contract; (E)
275 any stop-loss or excess loss insurance policy or contract providing for
276 the indemnification of or payment to a policy owner, a contract owner,
277 a plan or another person obligated to pay life, health or annuity
278 benefits; (F) any portion of a policy or contract to the extent that it
279 provides dividends, experience rating credits, voting rights or
280 provides that any fees or allowances be paid to any person, including,
281 but not limited to, the policy or contract holder, in connection with the
282 service to or administration of such policy or contract; (G) any policy

283 or contract issued in this state by a member insurer at a time when it
284 was not licensed or did not have a certificate of authority to issue such
285 policy or contract in this state; (H) any unallocated annuity contract
286 issued to an employee benefit plan protected under the federal Pension
287 Benefit Guaranty Corporation, regardless of whether the federal
288 Pension Benefit Guaranty Corporation has yet become liable to make
289 any payments with respect to the benefit plan; (I) any portion of an
290 unallocated annuity contract that is not issued to, or in connection with
291 a specific employee, union or association of natural persons benefit
292 plan or a government lottery; (J) any subscriber contract issued by a
293 health care center; (K) a contractual agreement that establishes the
294 insurer's obligation by reference to a portfolio of assets that is not
295 owned or possessed by the insurance company; (L) an obligation that
296 does not arise under the express written terms of the policy or contract
297 issued by the insurer to the contract owner or policy owner, including,
298 but not limited to, [;] (i) A] (i) a claim based on marketing materials, [;]
299 (ii) a claim based on side letters, riders or other documents that were
300 issued by the insurer without meeting applicable policy form filing or
301 approval requirements, [;] (iii) a misrepresentation of or regarding
302 policy benefits, [;] (iv) an extra-contractual claim, [;] or (v) a claim for
303 penalties or consequential or incidental damages; (M) a contractual
304 agreement that establishes the member insurer's obligations to provide
305 a book value accounting guaranty for defined contribution benefit plan
306 participants by reference to a portfolio of assets that is owned by the
307 benefit plan or its trustee, which in each case is not an affiliate of the
308 member insurer; [and] (N) a portion of a policy or contract to the
309 extent it provides for interest or other changes in value to be
310 determined by the use of an index or other external reference stated in
311 the policy or contract, but [which] that have not been credited to the
312 policy or contract, or as to which the policy or contract owner's rights
313 are subject to forfeiture, as of the date the member insurer becomes an
314 impaired or insolvent insurer under sections 38a-858 to 38a-875,
315 inclusive, whichever is earlier. If a policy's or contract's interest or
316 changes in value are credited less frequently than annually, then for
317 purposes of determining the values that have been credited and are

318 not subject to forfeiture under this subparagraph, the interest or
319 change in value determined by using the procedures defined in the
320 policy or contract shall be credited as if the contractual date of
321 crediting interest or changing values was the date of impairment or
322 insolvency, whichever is earlier, and shall not be subject to forfeiture;
323 and (O) any policy or contract providing hospital, medical,
324 prescription drugs or other health care benefits pursuant to Part C, 42
325 USC 1395w21 et seq., or Part D, 42 USC 1395w101 et seq., as both may
326 be amended from time to time, or any regulations issued thereunder.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2015</i>	38a-838(5) and (6)
Sec. 2	<i>October 1, 2015</i>	38a-841(a)
Sec. 3	<i>October 1, 2015</i>	38a-843(a) and (b)
Sec. 4	<i>October 1, 2015</i>	38a-860(f)

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:*** None***Municipal Impact:*** None***Explanation***

The bill makes several statutory changes concerning insurance guaranty associations. As these changes affect private insurance transactions, there is no state or municipal fiscal impact.

House "A" added self-insurers and group self-insurers to the exemptions specified in the underlying bill. There was no associated state or municipal fiscal impact.

The Out Years***State Impact:*** None***Municipal Impact:*** None

OLR Bill Analysis**HB 6868 (as amended by House "A")*****AN ACT CONCERNING THE CONNECTICUT INSURANCE
GUARANTY ASSOCIATIONS.****SUMMARY:**

This bill makes changes in the laws governing the Connecticut Insurance Guaranty Association (CIGA) and the Connecticut Life and Health Insurance Guaranty Association (CLHIGA). CIGA and CLHIGA pay certain insurance claims when an insurer becomes insolvent and is no longer able to meet its obligations. The bill:

1. requires CIGA to cover certain claims arising from policies an insolvent insurer acquired through a merger or acquisition;
2. changes the point at which CIGA payments are triggered from a determination of insolvency to a final order of liquidation; and
3. specifies that CIGA is not responsible for paying certain claims, including those arising from policies issued by surplus lines carriers (i.e., non-admitted insurers).

It also increases the coverage limit for CIGA, from \$400,000 to \$500,000, for claims arising from policies of insurers placed into liquidation with a finding of insolvency on or after October 1, 2015. By law, CIGA also pays (1) the full amount of workers' compensation claims and (2) one-half of unearned premiums up to \$2,000.

The bill specifies that CLHIGA is not responsible for claims arising from policies providing hospital, medical, prescription drug, or other health care benefits pursuant to Medicare Parts C or D.

The bill also makes minor, technical, and conforming changes.

*House Amendment "A" specifies that CIGA is not responsible for claims arising from policies originally issued by self-insurers or group self-insurers. This is also the case under existing law.

EFFECTIVE DATE: October 1, 2015

CIGA OBLIGATIONS

Covered Claims

The bill expands the claims CIGA must cover to include claims from policies that an insurer, who subsequently becomes insolvent, acquired through a merger or acquisition. Under the bill, covered claims are those the insurer assumed as a direct obligation:

1. by acquiring another insurer's assets and assuming its liabilities or
2. through an assumption reinsurance transaction (i.e., where one insurer assumes liability for another insurer's obligations).

By law, (1) the claimant or insured must be a Connecticut resident at the time of the insured event or (2) the claim must be a first party claim for damage to property permanently located in Connecticut. The bill specifies that the residence of claimants or insureds other than individuals (e.g., businesses) is the state where their principal place of business is located at the time of the insured event.

The bill specifies that CIGA is not responsible for:

1. claims arising from policies originally issued by a surplus lines carrier, risk retention group (i.e., a type of captive insurer or self-insured group organized under state and federal laws), self-insurer, or group self-insurer;
2. obligations assumed by an insolvent insurer after a delinquency proceeding starts, unless the claim would have been covered regardless of the insolvent insurer assuming it; and
3. obligations assumed by an insolvent insurer in a transaction in

which the original insurer remains separately liable.

Determinations of Insolvency and Final Orders of Liquidation

The bill changes the point at which insurers are considered insolvent for purposes of triggering CIGA coverage. Under current law, an insurer must be determined insolvent by a court of competent jurisdiction. Under the bill, an insurer must have a final order of liquidation with a finding of insolvency entered against it by a court of competent jurisdiction in the insurer's domiciled state. The bill makes corresponding conforming changes.

BACKGROUND

CIGA and CLHIGA

By law, eligible insurers must participate in and pay assessments to CIGA or CLHIGA, as applicable. If an insurance company defaults, the guaranty association pays valid claims of policyholders and other claimants up to the dollar limits of the applicable policy, subject to minimum and maximum limits fixed by state law. CIGA covers automobile, property and casualty, and workers' compensation insurance, among other types of insurance. CLHIGA covers direct, non-group life, health, and annuity policies.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 1 (03/10/2015)