



House of Representatives

File No. 635

General Assembly

January Session, 2021

(Reprint of File No. 346)

House Bill No. 6590
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 6, 2021

**AN ACT PROHIBITING CERTAIN INSURANCE DISCRIMINATION AND
ESTABLISHING A TASK FORCE TO STUDY INSURANCE COSTS
BORNE BY BUSINESSES LOCATED IN DISTRESSED
MUNICIPALITIES.**

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

1 Section 1. Section 38a-816 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2021*):

3 The following are defined as unfair methods of competition and
4 unfair and deceptive acts or practices in the business of insurance:

5 (1) Misrepresentations and false advertising of insurance policies.
6 Making, issuing or circulating, or causing to be made, issued or
7 circulated, any estimate, illustration, circular or statement, sales
8 presentation, omission or comparison which: (A) Misrepresents the
9 benefits, advantages, conditions or terms of any insurance policy; (B)
10 misrepresents the dividends or share of the surplus to be received, on
11 any insurance policy; (C) makes any false or misleading statements as

12 to the dividends or share of surplus previously paid on any insurance
13 policy; (D) is misleading or is a misrepresentation as to the financial
14 condition of any person, or as to the legal reserve system upon which
15 any life insurer operates; (E) uses any name or title of any insurance
16 policy or class of insurance policies misrepresenting the true nature
17 thereof; (F) is a misrepresentation, including, but not limited to, an
18 intentional misquote of a premium rate, for the purpose of inducing or
19 tending to induce to the purchase, lapse, forfeiture, exchange,
20 conversion or surrender of any insurance policy; (G) is a
21 misrepresentation for the purpose of effecting a pledge or assignment of
22 or effecting a loan against any insurance policy; or (H) misrepresents
23 any insurance policy as being shares of stock.

24 (2) False information and advertising generally. Making, publishing,
25 disseminating, circulating or placing before the public, or causing,
26 directly or indirectly, to be made, published, disseminated, circulated or
27 placed before the public, in a newspaper, magazine or other publication,
28 or in the form of a notice, circular, pamphlet, letter or poster, or over any
29 radio or television station, or in any other way, an advertisement,
30 announcement or statement containing any assertion, representation or
31 statement with respect to the business of insurance or with respect to
32 any person in the conduct of his insurance business, which is untrue,
33 deceptive or misleading.

34 (3) Defamation. Making, publishing, disseminating or circulating,
35 directly or indirectly, or aiding, abetting or encouraging the making,
36 publishing, disseminating or circulating of, any oral or written
37 statement or any pamphlet, circular, article or literature which is false
38 or maliciously critical of or derogatory to the financial condition of an
39 insurer, and which is calculated to injure any person engaged in the
40 business of insurance.

41 (4) Boycott, coercion and intimidation. Entering into any agreement
42 to commit, or by any concerted action committing, any act of boycott,
43 coercion or intimidation resulting in or tending to result in unreasonable
44 restraint of, or monopoly in, the business of insurance.

45 (5) False financial statements. Filing with any supervisory or other
46 public official, or making, publishing, disseminating, circulating or
47 delivering to any person, or placing before the public, or causing,
48 directly or indirectly, to be made, published, disseminated, circulated or
49 delivered to any person, or placed before the public, any false statement
50 of financial condition of an insurer with intent to deceive; or making any
51 false entry in any book, report or statement of any insurer with intent to
52 deceive any agent or examiner lawfully appointed to examine into its
53 condition or into any of its affairs, or any public official to whom such
54 insurer is required by law to report, or who has authority by law to
55 examine into its condition or into any of its affairs, or, with like intent,
56 wilfully omitting to make a true entry of any material fact pertaining to
57 the business of such insurer in any book, report or statement of such
58 insurer.

59 (6) Unfair claim settlement practices. Committing or performing with
60 such frequency as to indicate a general business practice any of the
61 following: (A) Misrepresenting pertinent facts or insurance policy
62 provisions relating to coverages at issue; (B) failing to acknowledge and
63 act with reasonable promptness upon communications with respect to
64 claims arising under insurance policies; (C) failing to adopt and
65 implement reasonable standards for the prompt investigation of claims
66 arising under insurance policies; (D) refusing to pay claims without
67 conducting a reasonable investigation based upon all available
68 information; (E) failing to affirm or deny coverage of claims within a
69 reasonable time after proof of loss statements have been completed; (F)
70 not attempting in good faith to effectuate prompt, fair and equitable
71 settlements of claims in which liability has become reasonably clear; (G)
72 compelling insureds to institute litigation to recover amounts due under
73 an insurance policy by offering substantially less than the amounts
74 ultimately recovered in actions brought by such insureds; (H)
75 attempting to settle a claim for less than the amount to which a
76 reasonable man would have believed he was entitled by reference to
77 written or printed advertising material accompanying or made part of
78 an application; (I) attempting to settle claims on the basis of an

79 application which was altered without notice to, or knowledge or
80 consent of the insured; (J) making claims payments to insureds or
81 beneficiaries not accompanied by statements setting forth the coverage
82 under which the payments are being made; (K) making known to
83 insureds or claimants a policy of appealing from arbitration awards in
84 favor of insureds or claimants for the purpose of compelling them to
85 accept settlements or compromises less than the amount awarded in
86 arbitration; (L) delaying the investigation or payment of claims by
87 requiring an insured, claimant, or the physician of either to submit a
88 preliminary claim report and then requiring the subsequent submission
89 of formal proof of loss forms, both of which submissions contain
90 substantially the same information; (M) failing to promptly settle claims,
91 where liability has become reasonably clear, under one portion of the
92 insurance policy coverage in order to influence settlements under other
93 portions of the insurance policy coverage; (N) failing to promptly
94 provide a reasonable explanation of the basis in the insurance policy in
95 relation to the facts or applicable law for denial of a claim or for the offer
96 of a compromise settlement; (O) using as a basis for cash settlement with
97 a first party automobile insurance claimant an amount which is less than
98 the amount which the insurer would pay if repairs were made unless
99 such amount is agreed to by the insured or provided for by the
100 insurance policy.

101 (7) Failure to maintain complaint handling procedures. Failure of any
102 person to maintain complete record of all the complaints which it has
103 received since the date of its last examination. This record shall indicate
104 the total number of complaints, their classification by line of insurance,
105 the nature of each complaint, the disposition of these complaints, and
106 the time it took to process each complaint. For purposes of this
107 [subsection] subdivision "complaint" means any written
108 communication primarily expressing a grievance.

109 (8) Misrepresentation in insurance applications. Making false or
110 fraudulent statements or representations on or relative to an application
111 for an insurance policy for the purpose of obtaining a fee, commission,
112 money or other benefit from any insurer, producer or individual.

113 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, as
114 amended by this act, 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829.
115 None of the following practices shall be considered discrimination
116 within the meaning of section 38a-446 or 38a-488 or a rebate within the
117 meaning of section 38a-825: (A) Paying bonuses to policyholders or
118 otherwise abating their premiums in whole or in part out of surplus
119 accumulated from nonparticipating insurance, provided any such
120 bonuses or abatement of premiums shall be fair and equitable to
121 policyholders and for the best interests of the company and its
122 policyholders; (B) in the case of policies issued on the industrial debit
123 plan, making allowance to policyholders who have continuously for a
124 specified period made premium payments directly to an office of the
125 insurer in an amount which fairly represents the saving in collection
126 expense; (C) readjustment of the rate of premium for a group insurance
127 policy based on loss or expense experience, or both, at the end of the
128 first or any subsequent policy year, which may be made retroactive for
129 such policy year.

130 (10) Notwithstanding any provision of any policy of insurance,
131 certificate or service contract, whenever such insurance policy or
132 certificate or service contract provides for reimbursement for any
133 services which may be legally performed by any practitioner of the
134 healing arts licensed to practice in this state, reimbursement under such
135 insurance policy, certificate or service contract shall not be denied
136 because of race, color or creed nor shall any insurer make or permit any
137 unfair discrimination against particular individuals or persons so
138 licensed.

139 (11) Favored agent or insurer: Coercion of debtors. (A) No person
140 may (i) require, as a condition precedent to the lending of money or
141 extension of credit, or any renewal thereof, that the person to whom
142 such money or credit is extended or whose obligation the creditor is to
143 acquire or finance, negotiate any policy or contract of insurance through
144 a particular insurer or group of insurers or producer or group of
145 producers; (ii) unreasonably disapprove the insurance policy provided
146 by a borrower for the protection of the property securing the credit or

147 lien; (iii) require directly or indirectly that any borrower, mortgagor,
148 purchaser, insurer or producer pay a separate charge, in connection
149 with the handling of any insurance policy required as security for a loan
150 on real estate or pay a separate charge to substitute the insurance policy
151 of one insurer for that of another; or (iv) use or disclose information
152 resulting from a requirement that a borrower, mortgagor or purchaser
153 furnish insurance of any kind on real property being conveyed or used
154 as collateral security to a loan, when such information is to the
155 advantage of the mortgagee, vendor or lender, or is to the detriment of
156 the borrower, mortgagor, purchaser, insurer or the producer complying
157 with such a requirement.

158 (B) (i) Subparagraph (A)(iii) of this subdivision shall not include the
159 interest which may be charged on premium loans or premium
160 advancements in accordance with the security instrument. (ii) For
161 purposes of subparagraph (A)(ii) of this subdivision, such disapproval
162 shall be deemed unreasonable if it is not based solely on reasonable
163 standards uniformly applied, relating to the extent of coverage required
164 and the financial soundness and the services of an insurer. Such
165 standards shall not discriminate against any particular type of insurer,
166 nor shall such standards call for the disapproval of an insurance policy
167 because such policy contains coverage in addition to that required. (iii)
168 The commissioner may investigate the affairs of any person to whom
169 this subdivision applies to determine whether such person has violated
170 this subdivision. If a violation of this subdivision is found, the person in
171 violation shall be subject to the same procedures and penalties as are
172 applicable to other provisions of section 38a-815, subsections (b) and (e)
173 of section 38a-817 and this section. (iv) For purposes of this section,
174 "person" includes any individual, corporation, limited liability
175 company, association, partnership or other legal entity.

176 (12) Refusing to insure, refusing to continue to insure or limiting the
177 amount, extent or kind of coverage available to an individual or
178 charging an individual a different rate for the same coverage because of
179 physical disability, mental or nervous condition as set forth in section
180 38a-488a or intellectual disability, except where the refusal, limitation or

181 rate differential is based on sound actuarial principles or is related to
182 actual or reasonably anticipated experience.

183 (13) Refusing to insure, refusing to continue to insure or limiting the
184 amount, extent or kind of coverage available to an individual or
185 charging an individual a different rate for the same coverage solely
186 because of blindness or partial blindness. For purposes of this
187 subdivision, "refusal to insure" includes the denial by an insurer of
188 disability insurance coverage on the grounds that the policy defines
189 "disability" as being presumed in the event that the insured is blind or
190 partially blind, except that an insurer may exclude from coverage any
191 disability, consisting solely of blindness or partial blindness, when such
192 condition existed at the time the policy was issued. Any individual who
193 is blind or partially blind shall be subject to the same standards of sound
194 actuarial principles or actual or reasonably anticipated experience as are
195 sighted persons with respect to all other conditions, including the
196 underlying cause of the blindness or partial blindness.

197 (14) Refusing to insure, refusing to continue to insure or limiting the
198 amount, extent or kind of coverage available to an individual or
199 charging an individual a different rate for the same coverage because of
200 exposure to diethylstilbestrol through the female parent.

201 (15) (A) Failure by an insurer, or any other entity responsible for
202 providing payment to a health care provider pursuant to an insurance
203 policy, to pay accident and health claims, including, but not limited to,
204 claims for payment or reimbursement to health care providers, within
205 the time periods set forth in subparagraph (B) of this subdivision, unless
206 the Insurance Commissioner determines that a legitimate dispute exists
207 as to coverage, liability or damages or that the claimant has fraudulently
208 caused or contributed to the loss. Any insurer, or any other entity
209 responsible for providing payment to a health care provider pursuant
210 to an insurance policy, who fails to pay such a claim or request within
211 the time periods set forth in subparagraph (B) of this subdivision shall
212 pay the claimant or health care provider the amount of such claim plus
213 interest at the rate of fifteen per cent per annum, in addition to any other

214 penalties which may be imposed pursuant to sections 38a-11, 38a-25,
215 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64,
216 inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129
217 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to
218 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
219 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
220 inclusive. Whenever the interest due a claimant or health care provider
221 pursuant to this section is less than one dollar, the insurer shall deposit
222 such amount in a separate interest-bearing account in which all such
223 amounts shall be deposited. At the end of each calendar year each such
224 insurer shall donate such amount to The University of Connecticut
225 Health Center.

226 (B) Each insurer or other entity responsible for providing payment to
227 a health care provider pursuant to an insurance policy subject to this
228 section, shall pay claims not later than:

229 (i) For claims filed in paper format, sixty days after receipt by the
230 insurer of the claimant's proof of loss form or the health care provider's
231 request for payment filed in accordance with the insurer's practices or
232 procedures, except that when there is a deficiency in the information
233 needed for processing a claim, as determined in accordance with section
234 38a-477, the insurer shall (I) send written notice to the claimant or health
235 care provider, as the case may be, of all alleged deficiencies in
236 information needed for processing a claim not later than thirty days
237 after the insurer receives a claim for payment or reimbursement under
238 the contract, and (II) pay claims for payment or reimbursement under
239 the contract not later than thirty days after the insurer receives the
240 information requested; and

241 (ii) For claims filed in electronic format, twenty days after receipt by
242 the insurer of the claimant's proof of loss form or the health care
243 provider's request for payment filed in accordance with the insurer's
244 practices or procedures, except that when there is a deficiency in the
245 information needed for processing a claim, as determined in accordance
246 with section 38a-477, the insurer shall (I) notify the claimant or health

247 care provider, as the case may be, of all alleged deficiencies in
248 information needed for processing a claim not later than ten days after
249 the insurer receives a claim for payment or reimbursement under the
250 contract, and (II) pay claims for payment or reimbursement under the
251 contract not later than ten days after the insurer receives the information
252 requested.

253 (C) As used in this subdivision, "health care provider" means a person
254 licensed to provide health care services under chapter 368d, chapter
255 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c,
256 inclusive, or chapter 400j.

257 (16) Failure to pay, as part of any claim for a damaged motor vehicle
258 under any automobile insurance policy where the vehicle has been
259 declared to be a constructive total loss, an amount equal to the sum of
260 (A) the settlement amount on such vehicle plus, whenever the insurer
261 takes title to such vehicle, (B) an amount determined by multiplying
262 such settlement amount by a percentage equivalent to the current sales
263 tax rate established in section 12-408. For purposes of this subdivision,
264 "constructive total loss" means the cost to repair or salvage damaged
265 property, or the cost to both repair and salvage such property, equals or
266 exceeds the total value of the property at the time of the loss.

267 (17) Any violation of section 42-260, by an extended warranty
268 provider subject to the provisions of said section, including, but not
269 limited to: (A) Failure to include all statements required in subsections
270 (c) and (f) of section 42-260 in an issued extended warranty; (B) offering
271 an extended warranty without being (i) insured under an adequate
272 extended warranty reimbursement insurance policy or (ii) able to
273 demonstrate that reserves for claims contained in the provider's
274 financial statements are not in excess of one-half the provider's audited
275 net worth; (C) failure to submit a copy of an issued extended warranty
276 form or a copy of such provider's extended warranty reimbursement
277 policy form to the Insurance Commissioner.

278 (18) With respect to an insurance company, hospital service

279 corporation, health care center or fraternal benefit society providing
280 individual or group health insurance coverage of the types specified in
281 subdivisions (1), (2), (4), ~~(5)~~ (6), (10), (11) and (12) of section 38a-469,
282 refusing to insure, refusing to continue to insure or limiting the amount,
283 extent or kind of coverage available to an individual or charging an
284 individual a different rate for the same coverage because such
285 individual has been a victim of [family] domestic violence, as defined in
286 section 17b-112a.

287 (19) With respect to a property and casualty insurer delivering,
288 issuing for delivery, renewing, amending, continuing or endorsing a
289 property or casualty insurance policy, making any distinction or
290 discrimination against an individual in delivering, issuing for delivery,
291 renewing, amending, continuing, endorsing, offering, withholding,
292 cancelling or setting premiums for such policy, or in the terms of such
293 policy, because the individual has been a victim of domestic violence, as
294 defined in section 17b-112a.

295 [(19)] (20) With respect to an insurance company, hospital service
296 corporation, health care center or fraternal benefit society providing
297 individual or group health insurance coverage of the types specified in
298 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469,
299 refusing to insure, refusing to continue to insure or limiting the amount,
300 extent or kind of coverage available to an individual or charging an
301 individual a different rate for the same coverage because of genetic
302 information. Genetic information indicating a predisposition to a
303 disease or condition shall not be deemed a preexisting condition in the
304 absence of a diagnosis of such disease or condition that is based on other
305 medical information. An insurance company, hospital service
306 corporation, health care center or fraternal benefit society providing
307 individual health coverage of the types specified in subdivisions (1), (2),
308 (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be
309 prohibited from refusing to insure or applying a preexisting condition
310 limitation, to the extent permitted by law, to an individual who has been
311 diagnosed with a disease or condition based on medical information
312 other than genetic information and has exhibited symptoms of such

313 disease or condition. For the purposes of this [subsection] subdivision,
314 "genetic information" means the information about genes, gene
315 products or inherited characteristics that may derive from an individual
316 or family member.

317 ~~[(20)]~~ (21) Any violation of sections 38a-465 to 38a-465q, inclusive, as
318 amended by this act.

319 ~~[(21)]~~ (22) With respect to a managed care organization, as defined in
320 section 38a-478, failing to establish a confidentiality procedure for
321 medical record information, as required by section 38a-999.

322 ~~[(22)]~~ (23) Any violation of sections 38a-591d to 38a-591f, inclusive.

323 ~~[(23)]~~ (24) Any violation of section 38a-472j.

324 Sec. 2. Section 38a-447 of the general statutes is repealed and the
325 following is substituted in lieu thereof (*Effective October 1, 2021*):

326 No life insurance company doing business in this state may: (1) Make
327 any distinction or discrimination between persons on the basis of race,
328 sexual orientation, gender identity or status as a victim of domestic
329 violence as to the premiums or rates charged for policies upon the lives
330 of such persons; (2) demand or require greater premiums from persons
331 of one race, sexual orientation or gender identity than such as are at that
332 time required by that company from persons of another race, sexual
333 orientation or gender identity, or persons who have been victims of
334 domestic violence than such as are at that time required by that
335 company from persons who have not been victims of domestic violence,
336 of the same age, sex, general condition of health and hope of longevity;
337 or (3) make or require any rebate, diminution or discount on the basis
338 of race, sexual orientation, gender identity or status as a victim of
339 domestic violence upon the sum to be paid on any policy in case of the
340 death of any person insured, nor insert in the policy any condition, nor
341 make any stipulation whereby such person insured shall bind [himself,
342 his] such person, such person's heirs, executors, administrators or
343 assigns to accept any sum less than the full value or amount of such

344 policy, in case of a claim accruing thereon by reason of the death of such
345 person insured, other than such as are imposed upon all persons in
346 similar cases; and each such stipulation or condition so made or inserted
347 shall be void. For the purposes of this section, "victim of domestic
348 violence" has the same meaning as provided in section 17b-112a.

349 Sec. 3. Section 38a-465 of the general statutes is repealed and the
350 following is substituted in lieu thereof (*Effective October 1, 2021*):

351 As used in sections 38a-465 to 38a-465q, inclusive, and subdivision
352 [(20)] (21) of section 38a-816, as amended by this act:

353 (1) "Advertisement" means any written, electronic or printed
354 communication or any communication by means of recorded telephone
355 messages or transmitted on radio, television, the Internet or similar
356 communications media, including, but not limited to, film strips, motion
357 pictures and videos, published, disseminated, circulated or placed
358 before the public, directly or indirectly, for the purpose of creating an
359 interest in or inducing a person to purchase or sell, assign, devise,
360 bequest or transfer the death benefit or ownership of a life insurance
361 policy or an interest in a life insurance policy pursuant to a life
362 settlement contract.

363 (2) "Broker" means a person who, on behalf of an owner and for a fee,
364 commission or other valuable consideration, offers or attempts to
365 negotiate life settlement contracts between an owner and one or more
366 providers. "Broker" does not include an attorney, certified public
367 accountant or financial planner accredited by a nationally recognized
368 accreditation agency retained to represent the owner, whose
369 compensation is not paid directly or indirectly by a provider or any
370 other person except the owner.

371 (3) "Business of life settlements" means an activity involved in, but
372 not limited to, offering to enter into, soliciting, negotiating, procuring,
373 effectuating, monitoring or tracking of life settlement contracts.

374 (4) "Chronically ill" means: (A) Being unable to perform at least two

375 activities of daily living, including, but not limited to, eating, toileting,
376 transferring, bathing, dressing or continence; (B) requiring substantial
377 supervision to protect from threats to health and safety due to severe
378 cognitive impairment; or (C) having a level of disability similar to that
379 described in subparagraph (A) of this subdivision as determined by the
380 federal Secretary of Health and Human Services.

381 (5) "Commissioner" means the Insurance Commissioner.

382 (6) (A) "Financing entity" means an underwriter, placement agent,
383 lender, purchaser of securities, purchaser of a policy or certificate from
384 a provider, credit enhancer, or any entity that has a direct ownership in
385 a policy or certificate that is the subject of a life settlement contract:

386 (i) Whose principal activity related to the transaction is providing
387 funds to effect the life settlement contract or purchase of one or more
388 policies; and

389 (ii) Who has an agreement in writing with one or more providers to
390 finance the acquisition of life settlement contracts.

391 (B) "Financing entity" does not include a nonaccredited investor or a
392 purchaser.

393 (7) "Financing transaction" means any transaction in which a
394 provider obtains financing from a financing entity, including, but not
395 limited to, any secured or unsecured financing, any securitization
396 transaction or any securities offering which is registered or exempt from
397 registration under federal or state securities law.

398 (8) "Insured" means the person covered under the policy being
399 considered for sale in a life settlement contract.

400 (9) "Life expectancy" means the arithmetic mean of the number of
401 months the insured under the life insurance policy to be settled can be
402 expected to live as determined by a life expectancy company, life
403 settlement company or investor considering medical records and
404 experiential data.

405 (10) "Life insurance producer" means any person licensed in this state
406 as a resident or nonresident insurance producer who has received
407 qualification or authority for life insurance coverage or a life line
408 coverage pursuant to chapter 702.

409 (11) (A) "Life settlement contract" means:

410 (i) A written agreement entered into between a provider and an
411 owner, establishing the terms under which compensation or anything
412 of value will be paid, which compensation or thing of value is less than
413 the expected death benefit of the insurance policy or certificate, in return
414 for the owner's assignment, transfer, sale, devise or bequest of the death
415 benefit or any portion of an insurance policy or certificate of insurance
416 for compensation, provided the minimum value for a life settlement
417 contract shall be greater than a cash surrender value or accelerated
418 death benefit available at the time of an application for a life settlement
419 contract;

420 (ii) The transfer for compensation or value of ownership or beneficial
421 interest in a trust, or other entity that owns such policy, if the trust or
422 other entity was formed or availed of for the principal purpose of
423 acquiring one or more life insurance contracts, which life insurance
424 contract insures the life of a person residing in this state;

425 (iii) A written agreement for a loan or other lending transaction,
426 secured primarily by an individual or group life insurance policy; or

427 (iv) A premium finance loan made for a policy on or before the date
428 of issuance of the policy where (I) the loan proceeds are not used solely
429 to pay premiums for the policy and any costs or expenses incurred by
430 the lender or the borrower in connection with the financing, (II) the
431 owner receives, on the date of the premium finance loan, a guarantee of
432 the future life settlement value of the policy, or (III) the owner agrees on
433 the date of the premium finance loan to sell the policy, or any portion of
434 its death benefit, on any date following the issuance of the policy.

435 (B) "Life settlement contract" does not include:

436 (i) A policy loan by a life insurance company pursuant to the terms
437 of the life insurance policy or accelerated death provisions contained in
438 the life insurance policy, whether issued with the original policy or as a
439 rider;

440 (ii) A premium finance loan, as defined in subparagraph (A)(iv) of
441 this subdivision, or any loan made by a bank or other licensed financial
442 institution, provided neither default on such loan or the transfer of the
443 policy, in connection with such default, is pursuant to an agreement or
444 understanding with any other person for the purpose of evading
445 regulation under this part;

446 (iii) A collateral assignment of a life insurance policy by an owner;

447 (iv) A loan made by a lender that does not violate sections 38a-162 to
448 38a-170, inclusive, provided such loan is not described in subparagraph
449 (A) of this subdivision and is not otherwise within the definition of life
450 settlement contract;

451 (v) An agreement where all the parties are closely related to the
452 insured by blood or law or have a lawful substantial economic interest
453 in the continued life, health and bodily safety of the person insured, or
454 are trusts established primarily for the benefit of such parties;

455 (vi) Any designation, consent or agreement by an insured who is an
456 employee of an employer in connection with the purchase by the
457 employer, or trust established by the employer, of life insurance on the
458 life of the employee;

459 (vii) A bona fide business succession planning arrangement: (I)
460 Between one or more shareholders in a corporation or between a
461 corporation and one or more of its shareholders or one or more trusts
462 established by its shareholders; (II) between one or more partners in a
463 partnership or between a partnership and one or more of its partners or
464 one or more trusts established by its partners; or (III) between one or
465 more members in a limited liability company or between a limited
466 liability company and one or more of its members or one or more trusts

467 established by its members;

468 (viii) An agreement entered into by a service recipient or a trust
469 established by the service recipient, and a service provider or a trust
470 established by the service provider, that performs significant services
471 for the service recipient's trade or business; or

472 (ix) Any other contract, transaction or arrangement from the
473 definition of life settlement contract that the commissioner determines
474 is not of the type intended to be regulated by this part.

475 (12) "Net death benefit" means the amount of the life insurance policy
476 or certificate to be settled less any outstanding debts or liens.

477 (13) "Owner" means the owner of a life insurance policy or a
478 certificate holder under a group policy, with or without a terminal
479 illness, who enters or seeks to enter into a life settlement contract. For
480 the purposes of this part, an owner shall not be limited to an owner of a
481 life insurance policy or a certificate holder under a group policy that
482 insures the life of an individual with a terminal or chronic illness or
483 condition, except where specifically addressed. "Owner" does not
484 include: (A) Any provider or other licensee under this part; (B) a
485 qualified institutional buyer, as defined in Rule 144A of the federal
486 Securities Act of 1933, as amended from time to time; (C) a financing
487 entity; (D) a special purpose entity; or (E) a related provider trust.

488 (14) "Patient identifying information" means an insured's address,
489 telephone number, facsimile number, electronic mail address,
490 photograph or likeness, employer, employment status, Social Security
491 number or any other information that is likely to lead to the
492 identification of the insured.

493 (15) "Person" means a natural person or a legal entity, including, but
494 not limited to, an individual, partnership, limited liability company,
495 association, trust or corporation.

496 (16) "Policy" means an individual or group policy, group certificate,

497 contract or arrangement of life insurance owned by a resident of this
498 state, regardless of whether delivered or issued for delivery in this state.

499 (17) "Premium finance loan" means a loan made primarily for the
500 purposes of making premium payments on a life insurance policy,
501 which loan is secured by an interest in such life insurance policy.

502 (18) "Provider" means a person, other than an owner, who enters into
503 or effectuates a life settlement contract with an owner. "Provider" does
504 not include:

505 (A) Any bank, savings bank, savings and loan association or credit
506 union;

507 (B) A licensed lending institution, creditor or secured party pursuant
508 to a premium finance loan agreement that takes an assignment of a life
509 insurance policy or certificate issued pursuant to a group life insurance
510 policy as collateral for a loan;

511 (C) The insurer of a life insurance policy or rider providing
512 accelerated death benefits or riders pursuant to section 38a-457 or cash
513 surrender value;

514 (D) A natural person who enters into or effectuates no more than one
515 agreement in a calendar year for the transfer of a life insurance policy or
516 certificate issued pursuant to a group life insurance policy, for
517 compensation or any value less than the expected death benefit payable
518 under the policy;

519 (E) A purchaser;

520 (F) An authorized or eligible insurer that provides stop loss coverage
521 to a provider, purchaser, financing entity, special purpose entity or
522 related provider trust;

523 (G) A financing entity;

524 (H) A special purpose entity;

525 (I) A related provider trust;

526 (J) A broker; or

527 (K) An accredited investor or a qualified institutional buyer, as
528 defined in Rule 501 of Regulation D or Rule 144A, respectively, of the
529 federal Securities Act of 1933, as amended from time to time, who
530 purchases a life settlement policy from a provider.

531 (19) "Purchased policy" means a policy or group certificate that has
532 been acquired by a provider pursuant to a life settlement contract.

533 (20) "Purchaser" means a person who pays compensation or anything
534 of value as consideration for a beneficial interest in a trust that is vested
535 with, or for the assignment, transfer or sale of, an ownership or other
536 interest in a life insurance policy or a certificate issued pursuant to a
537 group life insurance policy that is the subject of a life settlement contract.

538 (21) "Related provider trust" means a titling trust or other trust
539 established by a licensed provider or a financing entity for the sole
540 purpose of holding the ownership or beneficial interest in purchased
541 policies in connection with a financing transaction.

542 (22) "Settled policy" means a life insurance policy or certificate that
543 has been acquired by a provider pursuant to a life settlement contract.

544 (23) "Special purpose entity" means a corporation, partnership, trust,
545 limited liability company or other similar entity formed solely to
546 provide, either directly or indirectly, access to institutional capital
547 markets (A) for a financing entity or provider, (B) in connection with a
548 transaction in which the securities in the special purpose entity are
549 acquired by the owner or by a qualified institutional buyer, as defined
550 in Rule 144A of the federal Securities Act of 1933, as amended from time
551 to time, or (C) the securities pay a fixed rate of return commensurate
552 with established asset-backed institutional capital markets.

553 (24) "Stranger-originated life insurance" means an act, practice or
554 arrangement to initiate a life insurance policy for the benefit of a third-

555 party investor who, at the time of policy origination, has no insurable
556 interest in the insured. Such practices include, but are not limited to,
557 cases in which life insurance is purchased with resources or guarantees
558 from or through a person or entity, who, at the time of policy inception,
559 could not lawfully initiate the policy himself or itself, and where, at the
560 time of inception, there is an arrangement or agreement, whether verbal
561 or written, to directly or indirectly transfer the ownership of the policy
562 or the policy benefits to a third-party. Trusts created to give the
563 appearance of insurable interest and used to initiate policies for
564 investors violate insurable interest laws and the prohibition against
565 wagering on life. Stranger-originated life insurance arrangements do
566 not include those practices set forth in subparagraph (B) of subdivision
567 (11) of this section.

568 (25) "Terminally ill" means having an illness or sickness that can
569 reasonably be expected to result in death in twenty-four months or less.

570 Sec. 4. (*Effective from passage*) (a) There is established a task force to
571 study the insurance costs borne by businesses located in distressed
572 municipalities in this state. Such study shall include, but need not be
573 limited to, an examination of the insurance underwriting practices
574 affecting, and the factors driving the insurance rates paid by, such
575 businesses.

576 (b) The task force shall consist of the following members:

577 (1) One appointed by the speaker of the House of Representatives,
578 who has experience advocating for the interests of groups that are
579 historically underrepresented in the business community;

580 (2) One appointed by the president pro tempore of the Senate, who is
581 an insurance producer licensed in this state;

582 (3) One appointed by the majority leader of the House of
583 Representatives;

584 (4) One appointed by the majority leader of the Senate;

585 (5) One appointed by the minority leader of the House of
586 Representatives, who has experience working for an insurer doing
587 business in this state;

588 (6) One appointed by the minority leader of the Senate;

589 (7) The Insurance Commissioner, or the commissioner's designee;
590 and

591 (8) Two appointed by the Governor, one of whom has experience
592 advocating for the interests of groups that are historically
593 underrepresented in the business community.

594 (c) Any member of the task force appointed under subdivision (1),
595 (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member
596 of the General Assembly.

597 (d) All initial appointments to the task force shall be made not later
598 than thirty days after the effective date of this section. Any vacancy shall
599 be filled by the appointing authority.

600 (e) The speaker of the House of Representatives and the president pro
601 tempore of the Senate shall select the chairpersons of the task force from
602 among the members of the task force. Such chairpersons shall schedule
603 the first meeting of the task force, which shall be held not later than sixty
604 days after the effective date of this section.

605 (f) The administrative staff of the joint standing committee of the
606 General Assembly having cognizance of matters relating to insurance
607 shall serve as administrative staff of the task force.

608 (g) Not later than January 1, 2022, the task force shall submit a report
609 on its findings and recommendations to the joint standing committee of
610 the General Assembly having cognizance of matters relating to
611 insurance, in accordance with the provisions of section 11-4a of the
612 general statutes. The task force shall terminate on the date that it
613 submits such report or January 1, 2022, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2021</i>	38a-816
Sec. 2	<i>October 1, 2021</i>	38a-447
Sec. 3	<i>October 1, 2021</i>	38a-465
Sec. 4	<i>from passage</i>	New section

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 22 \$	FY 23 \$
Insurance Dept.	GF - Potential Revenue Gain	Minimal	Minimal

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in a potential minimal revenue gain to the General Fund, to the extent the Insurance Commissioner assesses additional fines or penalties for violations of the Connecticut Unfair Insurance Practices Act (CUIPA). The bill prohibits discrimination for certain insurance products on the basis of sexual orientation, gender identity, or being a victim of domestic violence and makes such discrimination a violation of CUIPA. CUIPA fines can range from \$5,000 per violation up to a maximum of \$250,000 in aggregate penalties per entity in any six-month period.

The bill also establishes a temporary task force to study the insurance costs borne by businesses in distressed municipalities, and report on its findings. This will have no fiscal impact.

House "A" alters the membership of the task force and its focus, which does not change the fiscal impact of the underlying bill.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the amount of fines assessed.

OLR Bill Analysis**HB 6590 (as amended by House "A")******AN ACT PROHIBITING CERTAIN INSURANCE DISCRIMINATION AND ESTABLISHING A TASK FORCE TO STUDY INSURANCE COSTS BORNE BY BUSINESSES LOCATED IN DISTRESSED MUNICIPALITIES.*****SUMMARY**

This bill prohibits health carriers (e.g., insurers and HMOs) issuing disability income protection policies from refusing to insure a person, varying the terms of coverage, or charging a different rate for coverage because the person has been a victim of domestic violence. Current law prohibits health carriers issuing other types of health insurance policies from taking these actions because a person has been a family violence victim, which is an undefined term. The bill instead prohibits them from taking these actions because a person has been a victim of domestic violence, as defined in state law (see BACKGROUND).

The bill also prohibits:

1. property and casualty insurers from making any distinction or discrimination against a person when issuing, renewing, amending, or terminating a policy or setting premiums or coverage terms because the person has been a domestic violence victim and
2. life insurers from making any distinction or discrimination against a person in premiums, rates, or the amount payable on a policy because of the person's sexual orientation, gender identity, or domestic violence victim status (existing law already prohibits these actions based on a person's race).

Under the bill, any health carrier or insurer that violates the above prohibitions commits a Connecticut Unfair Insurance Practices Act

violation (see BACKGROUND).

The bill also establishes a nine-member task force to study the insurance costs borne by businesses in distressed municipalities. It specifies the appointing authorities and member qualifications. The task force must report findings and recommendations to the Insurance and Real Estate Committee by January 1, 2022. It terminates when it submits its report or January 1, 2022, whichever is later.

Lastly, the bill makes technical changes.

*House Amendment "A" makes changes to the task force by reducing its membership by two; adding qualifications for two members; and making its focus insurance costs, rather than "high" insurance costs, borne by certain businesses.

EFFECTIVE DATE: October 1, 2021, except the task force provisions are effective upon passage.

TASK FORCE

The bill establishes a task force to study the insurance costs borne by businesses in distressed municipalities. Under the bill, the task force must study, at a minimum, insurance underwriting practices affecting, and factors driving the insurance rates paid by, businesses in distressed municipalities.

The task force includes the insurance commissioner or his designee, and eight appointed members. The appointing authorities must make initial appointments by 30 days' after the bill's passage and fill any vacancies. Table 1 identifies the appointees' required qualifications, if any, and appointing authorities. Members appointed by legislative leaders may be legislators.

Table 1: Appointed Members' Qualifications and Appointing Authorities

<i>Appointing Authority</i>	<i>Number</i>	<i>Qualifications</i>
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House speaker	One	Must have experience advocating for the interests of groups historically underrepresented in the business community
Senate president pro tempore	One	Must be a Connecticut-licensed insurance producer
House majority leader	One	None
Senate majority leader	One	None
House minority leader	One	Must have experience working for an insurer doing business in Connecticut
Senate minority leader	One	None
Governor	Two	One must have experience advocating for the interests of groups historically underrepresented in the business community

Under the bill, the House speaker and Senate president pro tempore select the task force’s chairpersons from among the members. The chairpersons must schedule the first meeting and hold it by 60 days’ after the bill’s passage.

The Insurance and Real Estate Committee’s administrative staff serves as the task force’s administrative staff.

BACKGROUND

Victim of Domestic Violence

By law, “victim of domestic violence” means a person who has been abused or subjected to extreme cruelty by any of the following:

1. physical acts that resulted in or were threatened to result in physical injury,

2. sexual abuse,
3. sexual activity involving a child in the home,
4. being forced to participate in nonconsensual sexual acts or activities,
5. threats of or attempts at physical or sexual abuse,
6. mental abuse, or
7. neglect or deprivation of medical care (CGS § 17b-112a).

Connecticut Unfair Insurance Practices Act

The law prohibits engaging in unfair or deceptive acts or practices in the business of insurance. It authorizes the insurance commissioner to conduct investigations and hearings, issue cease and desist orders, impose fines, revoke or suspend licenses, and order restitution for per se violations (i.e., violations specifically listed in statute). The law also allows the commissioner to ask the attorney general to seek injunctive relief in Superior Court if he believes someone is engaging in other unfair or deceptive acts not specifically defined in statute.

Fines may be up to (1) \$5,000 per violation to a \$50,000 maximum or (2) \$25,000 per violation to a \$250,000 maximum in any six-month period if the violation was knowingly committed. The law also imposes a fine of up to \$50,000, in addition to or in lieu of a license suspension or revocation, for violating a cease and desist order.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 0 (03/22/2021)