



House of Representatives

General Assembly

File No. 191

January Session, 2011

Substitute House Bill No. 6509

House of Representatives, March 24, 2011

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

***AN ACT CONCERNING THE CONNECTICUT INSURANCE
GUARANTY ASSOCIATION ACT AND THE CONNECTICUT LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION ACT.***

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

1 Section 1. Section 38a-838 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2011*):

3 The following terms as used in sections 38a-836 to 38a-853,
4 inclusive, as amended by this act, unless the context otherwise requires
5 or a different meaning is specifically prescribed, shall have the
6 following meanings:

7 (1) "Account" means any one of the three accounts created by
8 section 38a-839, as amended by this act;

9 (2) "Affiliate" means [any affiliate, as defined in section 38a-1, of] a
10 person who, directly or indirectly, through one or more intermediaries,
11 controls, is controlled by or under common control with, another
12 person on December thirty-first of the year immediately preceding the

13 date the insurer becomes an insolvent insurer;

14 (3) "Association" means the Connecticut Insurance Guaranty
15 Association created under section 38a-839, as amended by this act;

16 (4) "Association similar to the association" means any guaranty
17 association, security fund or other insolvency mechanism that affords
18 protection similar to that of the association. "Association similar to the
19 association" includes any property and casualty insolvency mechanism
20 that obtains assessments or other contributions from insurers on a
21 preinsolvency basis;

22 (5) "Assumed claims transaction" means: (A) A transaction in which
23 claim and insurance policy obligations are assumed by an insolvent
24 insurer prior to the date of the entry of a final order of liquidation, by
25 means of a merger between such insolvent insurer and another entity
26 obligated under the policy; or (B) an assumption reinsurance
27 transaction in which all of the following have occurred: (i) Prior to the
28 date of the entry of a final order of liquidation, the insolvent insurer
29 assumed the claim or insurance policy obligations of another insurer or
30 entity; (ii) such assumption of obligations was approved by an
31 insurance regulator having jurisdiction over such assumption; and (iii)
32 as a result of such assumption, the claim or policy obligations became
33 the direct obligations of the insolvent insurer through novation;

34 (6) "Claimant" means any person instituting a covered claim, except
35 that no affiliate shall be a claimant;

36 [(4)] (7) "Commissioner" means the Insurance Commissioner;

37 (8) "Control" means the direct or indirect possession of the power to
38 direct or cause the direction of the management and policies of a
39 person, whether through the ownership of voting securities, by
40 contract other than a contract for goods or nonmanagement services,
41 or otherwise, unless such power is the result of an official position or
42 corporate office held by the person. Control shall be presumed to exist
43 if a person directly or indirectly owns, controls, holds with the power

44 to vote or holds proxies representing, ten per cent or more of any
45 voting securities of another person. Such presumption may be rebutted
46 by a showing that control does not exist in fact;

47 [(5)] (9) (A) "Covered claim" means an unpaid claim, including [, but
48 not limited to,] one submitted by a claimant for unearned premiums,
49 [which] that arises out of and is within the coverage and subject to the
50 applicable limits of an insurance policy to which sections 38a-836 to
51 38a-853, inclusive, as amended by this act, apply [issued by an insurer,
52 if such] if the insurer becomes an insolvent insurer [after October 1,
53 1971] and the policy was issued by the insurer or assumed by the
54 insurer in an assumed claims transaction, and [(A)] (i) the claimant or
55 insured is a resident of this state at the time of the insured event, [;] or
56 [(B)] (ii) the claim is a first party claim for damage to property with a
57 permanent location in this state, [, provided the term "covered claim"
58 shall] For purposes of this subparagraph, the residence of a claimant or
59 insured that is not an individual shall be the state in which such
60 claimant's or insured's principal place of business is located at the time
61 of the insured event.

62 (B) "Covered claim" does not include: [(i) any claim by or for the
63 benefit of any reinsurer, insurer, insurance pool, or underwriting
64 association, as subrogation recoveries or otherwise; provided that a
65 claim for any such amount, asserted against a person insured under a
66 policy issued by an insurer which has become an insolvent insurer,
67 which, if it were not a claim by or for the benefit of a reinsurer, insurer,
68 insurance pool or underwriting association, would be a "covered
69 claim" may be filed directly with the receiver of the insolvent insurer
70 but in no event shall any such claim be asserted against the insured of
71 such insolvent insurer, (ii) any claim by or on behalf of an individual
72 who is neither a citizen of the United States nor an alien legally
73 resident in the United States at the time of the insured event, or an
74 entity other than an individual whose principal place of business is not
75 in the United States at the time of the insured event, and it arises out of
76 an accident, occurrence, offense, act, error or omission that takes place
77 outside of the United States, or a loss to property normally located

78 outside of the United States or, if a workers' compensation claim, it
79 arises out of employment outside of the United States, (iii) any claim
80 by or on behalf of a person who is not a resident of this state, other
81 than a claim for compensation or any other benefit which arises out of
82 and is within the coverage of a workers' compensation policy, against
83 an insured whose net worth at the time the policy was issued or at any
84 time thereafter exceeded twenty-five million dollars, provided that an
85 insured's net worth for purposes of this section and section 38a-844
86 shall be deemed to include the aggregate net worth of the insured and
87 all of its subsidiaries as calculated on a consolidated basis, (iv) any
88 claim by or on behalf of an affiliate of the insolvent insurer at the time
89 the policy was issued or at the time of the insured event, or (v) any
90 claim arising out of a policy issued by an insurer which was not
91 licensed to transact insurance in this state either at the time the policy
92 was issued or when the insured event occurred] (i) Any amount
93 awarded as punitive or exemplary damages; (ii) any amount sought as
94 a return of premium under any retrospective rating plan; (iii) any
95 amount due as subrogation recoveries, reinsurance recoveries,
96 contribution or indemnification to any insurer, reinsurer, insurance
97 pool, underwriting association, health care center, hospital service
98 corporation, medical service corporation or self-insurer; (iv) any first
99 party claims by an insured that is an affiliate of the insolvent insurer;
100 (v) any fee or other expense relating to goods or services sought by or
101 on behalf of any attorney or other provider of goods or services
102 retained by the insolvent insurer or an insured prior to the date such
103 insurer was determined to be insolvent by a court of competent
104 jurisdiction; (vi) any fee or other expense relating to goods or services
105 sought by or on behalf of any attorney or other provider of goods or
106 services retained by an insured or claimant in connection with the
107 assertion or prosecution of a claim, covered or otherwise, against the
108 association; (vii) any claims for interest; or (viii) any claim filed with
109 the association or a liquidator for protection afforded under the
110 insured's policy for losses incurred but not reported;

111 [(6)] (10) (A) "Insolvent insurer" means an insurer;

112 [(A) (i) licensed] (i) (I) Licensed to transact insurance in this state
113 [either] at the time the policy was issued, when the obligation with
114 respect to the covered claim was assumed under an assumed claims
115 transaction or when the insured event occurred, and [(ii)] (II)
116 determined to be insolvent by a court of competent jurisdiction;

117 [(B) which] (ii) That is [(i)] (I) the legal successor of an insurer that
118 was licensed to transact insurance in this state either at the time the
119 policy was issued or when the insured event occurred, by reason of a
120 merger, provided such merger [is] was approved by an insurance
121 regulator having jurisdiction over such merger, and [(ii)] (II)
122 determined to be insolvent by a court of competent jurisdiction; or

123 [(C) which (i)] (iii) That (I) succeeds to the policy obligations of an
124 insurer that was licensed to transact insurance in this state either at the
125 time the policy was issued or when the insured event occurred, by
126 reason of a division whereby policies issued by such licensed insurer
127 are transferred to an insurer, and [(ii)] (II) is determined to be insolvent
128 by a court of competent jurisdiction, provided such division is
129 approved [(I)] in a jurisdiction that allows such division [,] and [(II)] by
130 an insurance regulator having jurisdiction over such division.

131 (B) "Insolvent insurer" [shall] does not [be construed to] mean any
132 insurer with respect to which an order, decree, judgment or finding of
133 insolvency, whether permanent or temporary in nature, or order of
134 rehabilitation or conservation [has been] was issued by a court of
135 competent jurisdiction prior to October 1, 1971;

136 (11) "Insured" means any named insured, additional insured,
137 vendor, lessor or other party identified as an insured under the policy;

138 [(7)] (12) "Member insurer" means any person who (A) writes any
139 kind of insurance to which sections 38a-836 to 38a-853, inclusive, as
140 amended by this act, apply under section 38a-837, including, but not
141 limited to, the exchange of reciprocal or interinsurance contracts, and
142 (B) is licensed to transact insurance in this state. An insurer shall cease
143 to be a member insurer effective on the day following the termination

144 or expiration of its license to transact the kinds of insurance to which
145 [said] sections 38a-836 to 38a-853, inclusive, as amended by this act,
146 apply, [however] except that such insurer shall remain liable as a
147 member insurer for (i) any obligations, including obligations for
148 assessments levied prior to the termination or expiration of the
149 insurer's license, and [for] (ii) assessments levied after the termination
150 or expiration [which] that relate to any insurer [which] that became an
151 insolvent insurer prior to the termination or expiration of such
152 insurer's license. In the case of such insurer, the average of its net
153 direct written premium for the five calendar years prior to expiration
154 or termination of its license, whether or not the insurer has net direct
155 written premium in the year preceding such expiration or termination,
156 shall be used as its assessment base for any year following such
157 expiration or termination in which the insurer has no direct written
158 premium;

159 [(8)] (13) "Net direct written premiums" means direct gross
160 premiums written in this state on insurance policies to which sections
161 38a-836 to 38a-853, inclusive, as amended by this act, apply, including
162 policy and membership fees, less return premiums, [thereon]
163 premiums on policies not taken and dividends paid or credited to
164 policyholders on such direct business. [, provided the term "net] "Net
165 direct written premiums" [shall] does not include premiums on any
166 contract between insurers or reinsurers;

167 (14) "Novation" means the assumption of claim or insurance policy
168 obligations by an insolvent insurer as direct obligations through
169 consent of the policyholder, whether express or implied based upon
170 the circumstances, the notice provided and the conduct of the parties,
171 whereby the ceding insurer or entity initially obligated under the claim
172 or policy is released by the policyholder from fulfilling the claim or
173 policy obligation;

174 [(9)] (15) "Person" means an individual, aggregation of individuals,
175 corporation, partnership, association, joint stock company, business
176 trust, limited liability company, unincorporated organization,

177 voluntary organization, governmental entity or other legal entity;

178 [(10) "Residence" means, when used in reference to a corporation, its
179 principal place of business;

180 (11) "United States" has the meaning assigned to it by section 38a-1.]

181 (16) "Self-insurer" means a person that covers its liability through a
182 qualified individual or group self-insurance program or any other
183 formal program created for the specific purpose of covering liabilities
184 typically covered by insurance.

185 Sec. 2. Section 38a-839 of the general statutes is repealed and the
186 following is substituted in lieu thereof (*Effective October 1, 2011*):

187 There is created a nonprofit unincorporated legal entity to be known
188 as the Connecticut Insurance Guaranty Association. All insurers
189 defined as member insurers in [subdivision (8) of] section 38a-838, as
190 amended by this act, shall be members of said association as a
191 condition of their authority to transact insurance in this state. Said
192 association shall perform its functions under a plan of operation
193 established and approved under section 38a-842, as amended by this
194 act, and shall exercise its powers through a board of directors
195 established under section 38a-840, as amended by this act. For the
196 purposes of administration and assessment, said association shall be
197 divided into three separate accounts: (1) The workers' compensation
198 insurance account; (2) the automobile insurance account; and (3) an
199 account for all other insurance to which sections 38a-836 to 38a-853,
200 inclusive, as amended by this act, apply.

201 Sec. 3. Section 38a-840 of the general statutes is repealed and the
202 following is substituted in lieu thereof (*Effective October 1, 2011*):

203 (a) The board of directors of said association shall consist of not less
204 than five [nor] or more than nine persons, two of which shall be
205 persons representing the public and the remainder which shall be
206 persons representing insurers, serving terms as established in the plan
207 of operation under section 38a-842, as amended by this act.

208 (1) (A) The [members of the board of] directors of said board who
209 represent insurers shall be selected by member insurers and subject to
210 the approval of the commissioner. Vacancies on the board for such
211 directors shall be filled for the remaining period of the term by a
212 majority vote of the remaining [members] directors, subject to the
213 approval of the commissioner. [If no members are selected within sixty
214 days after October 1, 1971, the commissioner may appoint the initial
215 members of the board of directors.]

216 **[(b)]** In approving selections to said board, the commissioner shall
217 consider, among other things, whether all member insurers are fairly
218 represented.

219 (B) Any director of said board who represents an insurer shall be
220 terminated as a director if such insurer enters receivership. Such
221 termination shall be effective as of the date of the entry of the order of
222 receivership.

223 (2) The directors of said board who represent the public shall be
224 appointed by the commissioner. Vacancies on the board for such
225 directors shall be filled for the remaining period of the term by the
226 commissioner. No officer, director or employee of an insurer or any
227 person engaged in the business of insurance shall be eligible to serve as
228 a director of said board who represents the public.

229 **[(c) Members]** (b) The directors of said board shall receive no
230 compensation as such but shall be reimbursed from the assets of said
231 association for actual and necessary expenses incurred by them in
232 carrying out their official duties as members of the board of directors.

233 (c) If a director fails to attend three consecutive board meetings, the
234 board of directors may declare a vacancy, which shall be filled in
235 accordance with subsection (a) of this section.

236 (d) The commissioner may suspend a director from said board,
237 pending the outcome of an investigation or hearing by the
238 commissioner or the conclusion of a criminal proceeding, if the

239 commissioner has reasonable cause to believe such director failed to
240 disclose a known conflict of interest with respect to such director's
241 duties on said board, failed to take appropriate action based on a
242 known conflict of interest with respect to such director's duties on said
243 board, or has been indicted or charged with a felony. The insurer that
244 such director represents may replace such director prior to the
245 conclusion of such investigation, hearing or criminal proceeding. The
246 commissioner shall declare a vacancy if the investigation, hearing or
247 criminal proceeding substantiates the allegations or charges. Such
248 vacancy shall be filled in accordance with subsection (a) of this section.

249 Sec. 4. Section 38a-841 of the general statutes is repealed and the
250 following is substituted in lieu thereof (*Effective October 1, 2011*):

251 (a) Said association shall:

252 (1) Be obligated to the extent of the covered claims existing prior to
253 the determination of insolvency and arising within thirty days after the
254 determination of insolvency, or before the policy expiration date if less
255 than thirty days after the determination, or before the insured replaces
256 the policy or causes its cancellation, if [he] the insured does so within
257 thirty days of such determination, provided such obligation shall be
258 limited as follows: (A) With respect to covered claims for unearned
259 premiums, [to one-half of the unearned premium on any policy,
260 subject to] a maximum of [two] ten thousand dollars per policy; (B)
261 with respect to covered claims other than for unearned premiums,
262 such obligation shall include only that amount of each such claim
263 [which] that is in excess of one hundred dollars and is less than (i)
264 three hundred thousand dollars for claims arising under policies of
265 insurers determined to be insolvent prior to October 1, 2007, [and] (ii)
266 four hundred thousand dollars for claims arising under policies of
267 insurers determined to be insolvent on or after October 1, 2007, but
268 prior to October 1, 2011, and (iii) five hundred thousand dollars for
269 claims arising under policies of insurers determined to be insolvent on
270 or after October 1, 2011, except that said association shall pay the full
271 amount of any such claim arising out of a workers' compensation

272 policy, provided in no event shall said association be obligated [(i)] (I)
273 to any claimant in an amount in excess of the obligation of the
274 insolvent insurer under the policy form or coverage from which the
275 claim arises, [or (ii)] (II) for any claim filed with the association after
276 the expiration of two years from the date of the declaration of
277 insolvency unless such claim arose out of a workers' compensation
278 policy and was timely filed in accordance with section 31-294c, or (III)
279 to defend an insured subsequent to the association's payment or tender
280 of the association's covered claim obligation limit or the applicable
281 insurance policy limit, whichever is less;

282 (2) [be] Be deemed the insurer to the extent of its obligations, subject
283 to the limitations under sections 38a-836 to 38a-853, inclusive, as
284 amended by this act, on the covered claims and to such extent shall
285 have all rights, duties, and obligations of the insolvent insurer as if the
286 insurer had not become insolvent, including, but not limited to, the
287 right to pursue and retain salvage and subrogation recoverable on
288 covered claim obligations to the extent paid by the association. The
289 association shall not be deemed the insolvent insurer for purposes of
290 conferring jurisdiction;

291 (3) [allocate] Allocate claims paid and expenses incurred among the
292 three accounts, created by section 38a-839, as amended by this act,
293 separately, and assess member insurers separately (A) [in] with respect
294 [of] to each such account for such amounts as shall be necessary to pay
295 the obligations of said association under subdivision (1) of this
296 subsection [(a) of this section] subsequent to an insolvency; (B) the
297 expenses of handling covered claims subsequent to an insolvency; (C)
298 the cost of examinations under section 38a-846; and (D) such other
299 expenses as are authorized by sections 38a-836 to 38a-853, inclusive, as
300 amended by this act. The assessments of each member insurer shall be
301 in the proportion that the net direct written premiums of such member
302 insurer for the calendar year preceding the assessment on the kinds of
303 insurance in such account bears to the net direct written premiums of
304 all member insurers for the calendar year preceding the assessment on
305 the kinds of insurance in such account. Each member insurer shall be

306 notified of its assessment not later than thirty days before it is due. No
307 member insurer may be assessed in any year on any account an
308 amount greater than two per cent of that member insurer's net direct
309 written premiums for the calendar year preceding the assessment on
310 the kinds of insurance in said account. [, provided if, at the time an
311 assessment is levied on the "all other insurance" account, as defined in
312 subdivision (3) of section 38a-839, the board of directors finds that at
313 least fifty per cent of the total net direct written premiums of a member
314 insurer and all its affiliates, for the year on which such assessment is
315 based, were from policies issued or delivered in Connecticut, on risks
316 located in this state, such member insurer shall be assessed only on
317 such member insurer's net direct written premium that is attributable
318 to the kind of insurance that gives rise to each covered claim.] If the
319 maximum assessment, together with the other assets of said
320 association in any account, does not provide in any one year in any
321 account an amount sufficient to make all necessary payments from that
322 account, the funds available may be prorated and the unpaid portion
323 shall be paid as soon thereafter as funds become available. Said
324 association may defer, in whole or in part, the assessment of any
325 member insurer, if the assessment would cause the member insurer's
326 financial statement to reflect amounts of capital or surplus less than the
327 minimum amounts required for a certificate of authority by any
328 jurisdiction in which the member insurer is authorized to transact
329 insurance provided that during the period of deferment, no dividends
330 shall be paid to shareholders or policyholders. Deferred assessments
331 shall be paid when such payment will not reduce capital or surplus
332 below the minimum amounts required for a certificate of authority.
333 Such payments shall be refunded to those insurers receiving greater
334 assessments because of such deferment or, at the election of the
335 insurer, be credited against future assessments. Each member insurer
336 serving as a servicing facility may set off against any assessment,
337 authorized payments made on covered claims and expenses incurred
338 in the payment of such claims by such member insurer if they are
339 chargeable to the account in respect of which the assessment is made;

340 (4) [investigate] Investigate claims brought against said association,

341 [and] appoint and direct legal counsel retained under liability
342 insurance policies for the defense of covered claims, adjust,
343 compromise, settle [] and pay covered claims to the extent of said
344 association's obligations, and deny all other claims. The association
345 shall pay claims in any order it deems reasonable [] including, but not
346 limited to, payment in the order of receipt or by classification; [. It may
347 review settlements, releases and judgments to which the insolvent
348 insurer or its insureds were parties to determine the extent to which
349 such settlements, releases and judgments may be properly contested;]

350 (5) [notify] Notify such persons as the commissioner may direct
351 under subdivision (1) of subsection (b) of section 38a-843;

352 (6) [handle] Handle claims through its employees or through one or
353 more insurers or other persons designated by said association as
354 servicing facilities, provided such designation of a servicing facility
355 shall be subject to the approval of the commissioner, and may be
356 declined by a member insurer;

357 (7) [reimburse] Reimburse each such servicing facility for
358 obligations of said association paid by such facility and for expenses
359 incurred by such facility while handling claims on behalf of said
360 association and shall pay such other expenses of said association as are
361 authorized by sections 38a-836 to 38a-853, inclusive, as amended by
362 this act;

363 (8) Have the right to review and contest, as set forth in subsection
364 (d) of this section, settlements, releases, compromises, waivers and
365 judgments to which the insolvent insurer or its insureds were parties
366 prior to the date of the entry of the order of liquidation; and

367 (9) Make all reasonable efforts, in cooperation with other obligated
368 or potentially obligated associations similar to the association or their
369 authorized representatives, to coordinate and cooperate with receivers
370 or authorized representatives of insolvent insurers in a uniform
371 manner, including, but not limited to, through the use of Uniform Data
372 Standards promulgated or approved by the National Association of

373 Insurance Commissioners.

374 (b) Said association may: (1) Employ or retain such persons as are
375 necessary to handle claims and perform other duties of said
376 association; (2) borrow such funds as may be necessary from time to
377 time to effect the purposes of sections 38a-836 to 38a-853, inclusive, as
378 amended by this act, in accord with the plan of operation under
379 section 38a-842, as amended by this act; (3) sue or be sued; (4)
380 intervene as a matter of right as a party in any proceeding before any
381 court in this state that has jurisdiction over an insolvent insurer, as
382 defined in section 38a-838, as amended by this act; (5) negotiate and
383 become a party to such contracts as are necessary to carry out the
384 purpose of [said] sections 38a-836 to 38a-853, inclusive, as amended by
385 this act; (6) perform such other acts as are necessary or proper to
386 effectuate the purpose of said sections; (7) refund to the member
387 insurers in proportion to the contribution of each such member insurer
388 to that account, that amount by which the assets of the account exceed
389 the liabilities, if, at the end of any calendar year, the board of directors
390 finds that the assets of said association in any account exceed the
391 liabilities of that account as estimated by the board of directors for the
392 coming year; and (8) join one or more organizations comprised of
393 other states' associations similar to the association and designate such
394 organization to act as a liaison for said association and, to the extent
395 said association authorizes such organization, to bind said association
396 to agreements or settlements with receivers or authorized
397 representatives of insolvent insurers.

398 (c) (1) Each insurer paying an assessment under [sections 38a-836 to
399 38a-853, inclusive,] this section may offset, for an assessment paid in
400 the income year commencing prior to January 1, 2012, one hundred per
401 cent and for an assessment paid in income years commencing on or
402 after January 1, 2012, fifty per cent of the amount of such assessment
403 against its premium tax liability to this state under chapter 207. Such
404 offset shall be taken over a period of the five successive tax years
405 following the year of payment of the assessment, at the rate of twenty
406 per cent per year of [the assessment paid to the association] such offset.

407 Each insurer to which has been refunded by the association, pursuant
408 to subsection (b) of this section, all or a portion of an assessment
409 previously paid to the association by the insurer shall be required to
410 pay to the Department of Revenue Services an amount equal to the
411 total amount that has been claimed as an offset against the premiums
412 tax liability on the premiums tax return or returns, as the case may be,
413 filed by such insurer and that is attributable to such refunded
414 assessment, provided the amount required to be paid to said
415 department shall not exceed the amount of the refunded assessment. If
416 the amount of the refunded assessment exceeds the total amount that
417 has been claimed as an offset against the premiums tax liability on the
418 premiums tax return or returns filed by such insurer and that is
419 attributable to such refunded assessment, such excess may not be
420 claimed as an offset against the premiums tax liability on a premiums
421 tax return or returns filed by such insurer or, if the offset has been
422 transferred to another person pursuant to subdivision (2) of this
423 subsection, by such other person. For purposes of this subparagraph, if
424 the offset has been transferred to another person pursuant to
425 subdivision (2) of this subsection, the total amount that has been
426 claimed as an offset against the premiums tax liability on the
427 premiums tax return or returns filed by such insurer includes the total
428 amount that has been claimed as an offset against the premiums tax
429 liability on the premiums tax return or returns filed by such other
430 person. The association shall promptly notify the Commissioner of
431 Revenue Services of the name and address of the insurers to which
432 such refunds have been made, the amount of such refunds and the
433 date on which such refunds were mailed to such insurer. If the amount
434 that an insurer is required to pay to the Department of Revenue
435 Services has not been so paid on or before the forty-fifth day after the
436 date of mailing of such refunds, the insurer shall be liable for interest
437 on such amount at the rate of one per cent per month or fraction
438 thereof from such forty-fifth day to the date of payment.

439 (2) An insurer, in this subparagraph called "the transferor", may
440 transfer any offset provided under subdivision (1) of this subsection to
441 an affiliate, as defined in section 38a-1, of the transferor. Any such

442 transfer of the offset by the transferor and any subsequent transfer or
443 transfers of the same offset shall not affect the obligation of the
444 transferor to pay to the Department of Revenue Services any sums
445 which are acquired by refund from the association pursuant to
446 subsection (b) of this section and which are required to be paid to the
447 Department of Revenue Services pursuant to subdivision (1) of this
448 subsection. Such offset may be taken by any transferee only against the
449 transferee's premium tax liability to this state under chapter 207. The
450 Commissioner of Revenue Services shall not allow such offset to a
451 transferee against its premium tax liability unless the transferor, the
452 affiliate to which the offset was originally transferred, each subsequent
453 transferor and each subsequent transferee have filed such information
454 as may be required on forms provided by said commissioner with
455 respect to any such transfer or transfers on or before the due date of
456 the premium tax return on which such offset would have been taken
457 by the transferor if no transfer had been made by the transferor.

458 (3) A member insurer shall include in rates and premiums charged
459 for insurance policies to which sections 38a-836 to 38a-853, inclusive, as
460 amended by this act, apply, an amount sufficient to recoup a sum
461 equal to the assessment paid under this section by such insurer to said
462 association, less any amount (A) returned to such insurer by said
463 association, or (B) subject to an offset as set forth in subdivision (1) of
464 this subsection. Such rates and premiums shall not be deemed
465 excessive solely because they contain an additional amount reasonably
466 calculated to recoup all assessments paid by the member insurer to
467 said association.

468 (d) (1) In an action to enforce a settlement, release, compromise,
469 waiver or judgment to which the insolvent insurer or its insured was a
470 party prior to the date of the entry of the order of liquidation, the
471 association shall have the right to assert the following defenses in
472 addition to any defenses available to the insurer:

473 (A) The association is not bound by a settlement, release,
474 compromise or waiver executed by the insolvent insurer or its insured,

475 or any judgment entered against the insurer or its insured by consent
476 or through failure to exhaust all appeals, if the settlement, release,
477 compromise, waiver or judgment was: (i) Executed or entered within
478 one hundred twenty days prior to the date of the entry of the order of
479 liquidation and the insurer or insured did not use reasonable care in
480 executing or entering into the settlement, release, compromise or
481 waiver or did not pursue all reasonable appeals of an adverse
482 judgment; or (ii) executed by or entered against an insurer or its
483 insured based on default, fraud, collusion or the insurer's failure to
484 defend; and

485 (B) Any statutory defenses or rights of offset against any settlement,
486 release, compromise, waiver or judgment executed by or entered
487 against the insured or its insured.

488 (2) If a court of competent jurisdiction finds the association is not
489 bound by a settlement, release, compromise, waiver or judgment for
490 any of the reasons set forth in subparagraph (A) of subdivision (1) of
491 this subsection, such settlement, release, compromise, waiver or
492 judgment shall be set aside and the association shall be permitted to
493 defend any covered claim on its merits. Such settlement, release,
494 compromise, waiver or judgment shall not be considered as evidence
495 of liability or damages in connection with any claim brought against
496 the association or any other party under sections 38a-836 to 38a-853,
497 inclusive, as amended by this act;

498 (3) With respect to a judgment regarding any covered claim under
499 any decision, order, verdict or finding based on the default of the
500 insolvent insurer or its failure to defend, the association, on its own
501 behalf or on behalf of an insured under an insurance policy issued by
502 the insolvent insurer, may apply to set aside or make a motion to open
503 such judgment, decision, order, verdict or finding with the same court
504 or administrator that entered such judgment, decision, order, verdict
505 or finding, and shall be permitted to defend the covered claim on its
506 merits.

507 Sec. 5. Section 38a-842 of the general statutes is repealed and the

508 following is substituted in lieu thereof (*Effective October 1, 2011*):

509 (a) (1) Said association shall submit to the commissioner a plan of
510 operation and any amendments thereto necessary or suitable to assure
511 the fair, reasonable, and equitable administration of said association.
512 The plan of operation and any amendments thereto shall become
513 effective upon approval in writing by the commissioner.

514 (2) If said association fails to submit a suitable plan of operation
515 within ninety days following October 1, 1971, or if at any time
516 thereafter said association fails to submit suitable amendments to the
517 plan, the commissioner shall, after notice and hearing, adopt and
518 promulgate such reasonable regulations as are necessary or advisable
519 to effectuate the provisions of sections 38a-836 to 38a-853, inclusive, as
520 amended by this act. Such regulations shall continue in force until
521 modified by the commissioner or superseded by a plan submitted by
522 said association and approved by the commissioner.

523 (b) All member insurers shall comply with the plan of operation.

524 (c) The plan of operation shall: (1) Establish the procedures whereby
525 all the powers and duties of said association under section 38a-841, as
526 amended by this act, shall be performed; (2) establish procedures for
527 handling the assets of said association; (3) establish the number, the
528 terms of office and the amount and method of reimbursing members
529 of the board of directors under section 38a-840, as amended by this act;
530 (4) establish procedures by which claims may be filed with said
531 association and establish acceptable forms of proof of covered claims.
532 Notice of claims to the receiver or liquidator of the insolvent insurer
533 shall be deemed notice to said association or its agent and a list of such
534 claims shall be periodically submitted to said association or similar
535 organization having a like function to that of said association in
536 another state by the receiver or liquidator; (5) establish regular places
537 and times for meetings of the board of directors; (6) establish
538 procedures for records to be kept of all financial transactions of said
539 association, its agents, and the board of directors; (7) provide that any
540 member insurer aggrieved by any final action or decision of said

541 association may appeal to the commissioner within thirty days after
542 such action or decision; (8) establish the procedures whereby selections
543 for the board of directors shall be submitted to the commissioner; (9)
544 contain such additional provisions as may be necessary or proper for
545 the execution of the powers and duties of said association under
546 sections 38a-836 to 38a-853, inclusive, as amended by this act.

547 (d) The plan of operation may delegate any or all powers and duties
548 of said association, except those under subdivision (3) of subsection (a)
549 of section 38a-841, as amended by this act, and subdivision (2) of
550 subsection (b) of section 38a-841, as amended by this act, to a
551 corporation, association similar to the association, or other
552 organization [which] that performs or will perform functions similar to
553 those of said association, or its equivalent having a like function to that
554 of said association, in two or more states. Such a corporation,
555 association similar to the association or organization shall be
556 reimbursed by said association as a servicing facility would be
557 reimbursed and shall be paid by said association for its performance of
558 any other functions of said association. Any delegation under this
559 subsection shall take effect only with the approval of both the board of
560 directors and the commissioner, and may be made only to a
561 corporation, association, or organization [which] that extends
562 protection not substantially less favorable and effective than that
563 provided by sections 38a-836 to 38a-853, inclusive, as amended by this
564 act.

565 Sec. 6. Section 38a-844 of the general statutes is repealed and the
566 following is substituted in lieu thereof (*Effective October 1, 2011*):

567 (a) Any person recovering any moneys under sections 38a-836 to
568 38a-853, inclusive, as amended by this act, shall be deemed to have
569 assigned [his] such person's rights under the policy to said association
570 to the extent of [his] such person's recovery from said association.
571 Every insured or claimant seeking the protection of said sections shall
572 cooperate with said association to the same extent as such person
573 would have been required to cooperate with the insolvent insurer. Said

574 association shall have no cause of action against any insured of the
575 insolvent insurer for any sums it has paid out to such insured except
576 such causes of action as the insolvent insurer would have had if such
577 sums had been paid by the insolvent insurer. In the case of an
578 insolvent insurer operating on a plan with assessment liability,
579 payments of claims of said association shall not operate to reduce the
580 liability of insureds to the receiver, liquidator [,] or statutory successor
581 for unpaid assessments.

582 [(b) The receiver, liquidator, or statutory successor of an insolvent
583 insurer shall be bound by determinations of covered claim eligibility
584 under sections 38a-836 to 38a-853, inclusive, and by settlements of
585 claims made by said association or any similar organization having a
586 like function to that of said association in another state. The court
587 having jurisdiction shall grant such claims priority equal to that to
588 which the claimant would have been entitled in the absence of said
589 sections 38a-836 to 38a-853, inclusive, against the assets of the
590 insolvent insurer. The expenses of said association or any similar
591 organization having a like function to that of said association in
592 handling claims shall be accorded the same priority as the receiver's or
593 liquidator's expenses.]

594 (b) A reinsurer, insurer, insurance pool, underwriting association,
595 health care center, hospital service corporation, medical service
596 corporation or self-insurer shall have no cause of action against any
597 insured of the insolvent insurer for any amount due such reinsurer,
598 insurer, insurance pool, underwriting association, health care center,
599 hospital service corporation, medical service corporation or self-
600 insurer except to the extent such amount exceeds the association's
601 obligation limits set forth in section 38a-841, as amended by this act.

602 (c) Said association shall periodically file with the receiver or
603 liquidator of the insolvent insurer statements of the covered claims
604 paid by said association, the expenses paid for the processing of
605 covered claims paid or contested and estimates of anticipated claims
606 on said association, and expenses of processing such claims which

607 shall preserve the rights of said association against the assets of the
608 insolvent insurer.

609 (d) [(1) Except as provided in subdivision (2) of this subsection, the]
610 The association shall have the right to recover from the following
611 persons the amount of any covered claim paid on behalf of such
612 person pursuant to sections 38a-836 to 38a-853, inclusive, as amended
613 by this act: [(A)] (1) Any person who is an affiliate of the insolvent
614 insurer and whose liability obligations to other persons are satisfied in
615 whole or in part by payments made under this chapter; and [(B)] (2)
616 any insured whose net worth on December thirty-first of the year next
617 preceding the date the insurer becomes an insolvent insurer exceeds
618 fifty million dollars and whose liability obligations to other persons are
619 satisfied in whole or in part by payments made under said sections.
620 For purposes of this [subdivision] subsection, "insured" does not
621 include a [municipality, as defined in section 7-148,] governmental
622 entity or the Second Injury Fund, established in section 31-354.

623 [(2) The association shall have no right to recover pursuant to
624 subdivision (1) of this subsection from any nonprofit corporation
625 organized to deliver health services and social services to meet the
626 needs of the elderly, that is incorporated in this state and qualified as a
627 Section 501(c)(3) organization under the Internal Revenue Code of
628 1986, or any subsequent corresponding internal revenue code of the
629 United States, as amended from time to time, for any amount of
630 covered claims paid on behalf of such corporation on or after
631 December 1, 2001, provided the insolvent insurer was declared
632 insolvent prior to May 27, 2008. Any amounts recovered by the
633 association prior to May 27, 2008, from any such nonprofit corporation
634 or affiliate of such nonprofit corporation shall not be required to be
635 reimbursed to such nonprofit corporation or affiliate of such nonprofit
636 corporation.]

637 Sec. 7. Section 38a-845 of the general statutes is repealed and the
638 following is substituted in lieu thereof (*Effective October 1, 2011*):

639 (a) (1) Any person having a claim against an insurer under any

640 provision in an insurance policy [, other than a policy of an insolvent
641 insurer, which is also a covered claim under sections 38a-836 to 38a-
642 853, inclusive,] shall first exhaust [first his rights under such policy] all
643 coverage, including the right to a defense, provided by any other
644 insurance policy, regardless of whether such policy was issued by a
645 member insurer, if the claim arises from the same facts, injury or loss
646 that gave rise to a covered claim against the association. A claim
647 arising from the same facts, injury or loss shall be considered to have
648 occurred if a claim has arisen under a policy that provides liability
649 coverage to a person who may be jointly and severally liable as a
650 tortfeasor with a person insured under an insurance policy issued by
651 the insolvent insurer. This subdivision shall not apply to any right an
652 insured has under an insurance policy of an insolvent insurer or under
653 a life insurance policy.

654 (2) (A) Any amount payable on a covered claim under [said]
655 sections 38a-836 to 38a-853, inclusive, as amended by this act, shall be
656 reduced by the [amount recoverable under the claimant's insurance
657 policy or chapter 568.] full applicable limits stated in the other
658 insurance policy or by the amount of the recovery under the other
659 insurance policy as provided herein:

660 (i) The association shall receive a full credit for the stated limits,
661 unless the claimant demonstrates that the claimant used reasonable
662 efforts to exhaust all coverage and limits applicable under the other
663 insurance policy; or

664 (ii) The association shall receive a full credit for the amount of the
665 recovery if the claimant demonstrates that the claimant used
666 reasonable efforts to exhaust all coverage and limits applicable under
667 the other insurance policy.

668 (B) Any such credit shall be deducted from the lesser of (i) the
669 association's covered claim limit, (ii) the amount of the judgment or
670 settlement of the claim, or (iii) the full applicable limit stated in the
671 policy of the insolvent insurer. The association's obligation shall not
672 exceed the covered claim limits set forth in section 38a-841, as

673 amended by this act.

674 (C) No insured under an insurance policy issued by the insolvent
675 insurer shall be liable for any amount of the reduction made by the
676 association pursuant to this subdivision to any amount paid to a third-
677 party claimant.

678 (3) Except to the extent the claimant has a contractual right to a
679 defense under an insurance policy issued by another insurer and
680 except as otherwise limited under the provisions of sections 38a-836 to
681 38a-853, inclusive, as amended by this act, nothing in this section shall
682 relieve the association of its duty to defend under the policy issued by
683 the insolvent insurer.

684 (4) For purposes of this section, a claim under an insurance policy
685 other than a life insurance policy shall include, but not be limited to,
686 (A) a claim against a health care center, hospital service corporation,
687 medical service corporation or disability insurance company, and (B)
688 any amount payable by or on behalf of a self-insurer.

689 (b) Any person having a claim [which] that may be recovered under
690 more than one insurance guaranty association or [its equivalent having
691 a like function to that of said] association similar to the association
692 shall seek recovery first from the association operating in the area of
693 the residence of the insured, except that (1) if it is a first party claim for
694 damage to property with a permanent location, such person shall seek
695 recovery first from the association operating in the location of the
696 property, and (2) if it is a workers' compensation claim, such person
697 shall seek recovery first from the association operating in the area of
698 residence of the claimant. Any recovery under sections 38a-836 to 38a-
699 853, inclusive, as amended by this act, shall be reduced by the amount
700 recoverable from any other insurance guaranty association or [its
701 equivalent having a like function to that of said] association similar to
702 the association.

703 [(c) Any person having a claim under any governmental insurance
704 or guaranty program which such claim is also a covered claim shall be

705 required to first exhaust his rights under such program. Any amount
706 payable on a covered claim under sections 38a-836 to 38a-853,
707 inclusive, shall be reduced by any amount recoverable under such
708 program.]

709 Sec. 8. Section 38a-851 of the general statutes is repealed and the
710 following is substituted in lieu thereof (*Effective October 1, 2011*):

711 (a) All proceedings in which an insolvent insurer is a party or is
712 obligated to defend an insured as a party in any court in this state shall
713 be stayed for up to six months and for such additional time thereafter
714 as may be determined by the court from the date of declaration of
715 insolvency or from the time an ancillary proceeding is instituted in the
716 state, whichever is later, to permit proper defense by said association
717 of all pending causes of action in the case. [Whenever any covered
718 claims arise from a judgment under any decision, verdict or finding
719 based on the default of an insolvent insurer or based on such insolvent
720 insurer's failure to defend an insured, said association, either on its
721 own behalf or on behalf of such insured, may apply to have such
722 judgment, order, decision, verdict or finding set aside by the same
723 court or administrator that made such judgment, order, decision,
724 verdict or finding and said association may defend against any such
725 claim on the merits of the case.]

726 (b) The receiver, liquidator [, receiver] or statutory successor of an
727 insolvent insurer covered by sections 38a-836 to 38a-853, inclusive, as
728 amended by this act, shall permit access by the board or its authorized
729 representative to such of the insolvent insurer's records [which] that
730 the board determines are necessary for the board to carry out its
731 functions under said sections 38a-836 to 38a-853, inclusive, as amended
732 by this act, with regard to covered claims. The receiver, liquidator [,
733 receiver] or statutory successor shall provide the board or its
734 representative with copies of such records upon the request and at the
735 expense of the board.

736 Sec. 9. Section 38a-860 of the general statutes is repealed and the
737 following is substituted in lieu thereof (*Effective October 1, 2011*):

738 (a) Sections 38a-858 to 38a-875, inclusive, as amended by this act,
739 shall provide coverage for the policies and contracts specified in
740 subsection [(f)] (d) of this section to:

741 (1) [To] For a policy or certificate other than an unallocated annuity
742 contract or a structured settlement annuity, (A) any person, except for
743 a nonresident certificate holder under a group policy or contract, who
744 is the beneficiary, assignee or payee of the person covered under
745 [subdivision (2)] subparagraph (B) of this [subsection] subdivision,
746 regardless of where the person resides, and [(2)] (B) any person who is
747 the owner of, or certificate holder under, such policy or contract and in
748 each case who [(A)] (i) is a resident, or [(B)] (ii) is not a resident,
749 provided [(i)] (I) the insurer that issued such policy or contract is
750 domiciled in this state, [(ii)] (II) the state in which the person resides
751 has an association similar to the association created by this section and
752 sections 38a-837, 38a-838, as amended by this act, 38a-845, as amended
753 by this act, 38a-853, 38a-862, 38a-863, as amended by this act, 38a-865,
754 as amended by this act, and 38a-866, as amended by this act, and [(iii)]
755 (III) the person is not eligible for coverage by an association in any
756 other state because the insurer was not licensed in the state at the time
757 specified in the state's guaranty association law; [.]

758 [(b)] (2) For unallocated annuity contracts, [specified in subsection
759 (f) of this section, subdivisions (1) and (2) of subsection (a) of this
760 section shall not apply, and] except as provided in subsections [(d)] (b)
761 and [(e)] (c) of this section, [sections 38a-858 to 38a-875, inclusive, shall
762 apply to: (1) Any] (A) any person who is the owner of the unallocated
763 annuity contract if the contract is issued to, or in connection with, a
764 specific benefit plan whose plan sponsor has its principal place of
765 business in this state, [.] and [(2)] (B) any person who is the owner of
766 an unallocated annuity contract issued to, or in connection with,
767 government lotteries if the owners are residents; [.]

768 [(c)] (3) For structured settlement annuities, [specified in subsection
769 (f) of this section, subdivisions (1) and (2) of subsection (a) of this
770 section shall not apply, and] except as provided in subsections [(d)] (b)

771 and [(e)] (c) of this section, [sections 38a-858 to 38a-875, inclusive, shall
772 apply to] a person who is a payee under a structured settlement
773 annuity, or to a beneficiary of a payee if the payee is deceased, if the
774 payee: [(1)] (A) Is a resident, regardless of where the contract owner
775 resides, or [(2)] (B) is not a resident, provided [: (A) (i) The] (i) (I) the
776 contract owner of the structured settlement annuity is a resident, or
777 [(ii)] (II) the contract owner of the structured settlement annuity is not
778 a resident, but the insurer that issued the structured settlement annuity
779 is domiciled in this state, and the state in which the contract owner
780 resides has an association similar to the association created by sections
781 38a-858 to 38a-875, inclusive, as amended by this act, [;] and [(B)] (ii)
782 neither the payee, beneficiary or contract owner is eligible for coverage
783 by the association of the state in which the payee, beneficiary or
784 contract owner resides.

785 [(d)] (b) Sections 38a-858 to 38a-875, inclusive, as amended by this
786 act, shall not provide coverage to: (1) A person who is a payee or
787 beneficiary of a contract owner resident of this state, if the payee or
788 beneficiary is afforded any coverage by the association of another state;
789 or (2) a person covered under subdivision (2) of subsection [(b)] (a) of
790 this section, if any coverage is provided by the association of another
791 state to the person.

792 [(e)] (c) Sections 38a-858 to 38a-875, inclusive, as amended by this
793 act, shall provide coverage to a person who is a resident and, in special
794 circumstances, to a nonresident. In order to avoid duplicate coverage,
795 if a person who would otherwise receive coverage under sections 38a-
796 858 to 38a-875, inclusive, as amended by this act, is provided coverage
797 under the laws of any other state, the person shall not be provided
798 coverage under sections 38a-858 to 38a-875, inclusive, as amended by
799 this act. In determining the application of the provisions of this
800 subsection in situations where a person could be covered by the
801 association of more than one state, whether as an owner, payee,
802 beneficiary or assignee, sections 38a-858 to 38a-875, inclusive, as
803 amended by this act, shall be construed in conjunction with the laws of
804 other states to result in coverage by only one association.

805 [(f)] (d) (1) Sections 38a-858 to 38a-875, inclusive, as amended by this
806 act, shall provide coverage to the persons specified in [subsections (a)
807 to (d), inclusive,] subsections (a) and (b) of this section for direct,
808 nongroup life, health or annuity policies or contracts and supplemental
809 contracts to such policies or contracts, for certificates under direct
810 group policies and contracts, and for unallocated annuity contracts
811 issued by member insurers, except as limited by said sections. Annuity
812 contracts and certificates under group annuity contracts include, but
813 are not limited to, guaranteed investment contracts, deposit
814 administration contracts, unallocated funding agreements, allocated
815 funding agreements, structured settlement annuities, annuities issued
816 to or in connection with government lotteries and any immediate or
817 deferred annuity contracts.

818 (2) [Said sections] Sections 38a-858 to 38a-875, inclusive, as amended
819 by this act, shall not provide coverage for: (A) Any portion of a policy
820 or contract not guaranteed by the insurer, or under which the risk is
821 borne by the policy or contract holder; (B) any policy or contract of
822 reinsurance, unless assumption certificates have been issued pursuant
823 to the reinsurance policy or contract; (C) any portion of a policy or
824 contract to the extent that the rate of interest on which it is based or the
825 interest rate, crediting rate or similar factor determined by use of an
826 index or other external reference stated in the policy or contract
827 employed in calculating returns or changes in value (i) averaged over
828 the period of four years prior to the date on which the member insurer
829 becomes an impaired or insolvent insurer under sections 38a-858 to
830 38a-875, inclusive, as amended by this act, exceeds the rate of interest
831 determined by subtracting two percentage points from Moody's
832 corporate bond yield average averaged for that same four-year period
833 or for such lesser period if the policy or contract was issued less than
834 four years before the member insurer becomes an impaired or
835 insolvent insurer under sections 38a-858 to 38a-875, inclusive, as
836 amended by this act, whichever is earlier; and (ii) on and after the date
837 on which the member insurer becomes an impaired or insolvent
838 insurer under sections 38a-858 to 38a-875, inclusive, as amended by
839 this act, whichever is earlier, exceeds the rate of interest determined by

840 subtracting three percentage points from Moody's corporate bond
841 yield average as most recently available; (D) a portion of a policy or
842 contract issued to any plan or program of an employer, association or
843 similar entity to provide life, health or annuity benefits to its
844 employees or members to the extent that such plan or program is self-
845 funded or uninsured, including, but not limited to, benefits payable by
846 an employer, association or similar entity under (i) a multiple
847 employer welfare arrangement as defined in Section 514 of the federal
848 Employee Retirement Income Security Act of 1974, as amended from
849 time to time; (ii) a minimum premium group insurance plan; or (iii) an
850 administrative services only contract; (E) any stop-loss or excess loss
851 insurance policy or contract providing for the indemnification of or
852 payment to a policy owner, a contract owner, a plan or another person
853 obligated to pay life, health or annuity benefits; (F) any portion of a
854 policy or contract to the extent that it provides dividends, experience
855 rating credits, voting rights or provides that any fees or allowances be
856 paid to any person, including, but not limited to, the policy or contract
857 holder, in connection with the service to or administration of such
858 policy or contract; (G) any policy or contract issued in this state by a
859 member insurer at a time when it was not licensed or did not have a
860 certificate of authority to issue such policy or contract in this state; (H)
861 any unallocated annuity contract issued to an employee benefit plan
862 protected under the federal Pension Benefit Guaranty Corporation,
863 regardless of whether the federal Pension Benefit Guaranty
864 Corporation has yet become liable to make any payments with respect
865 to the benefit plan; (I) any portion of an unallocated annuity contract
866 that is not issued to, or in connection with a specific employee, union
867 or association of natural persons benefit plan or a government lottery;
868 (J) any subscriber contract issued by a health care center; (K) a
869 contractual agreement that establishes the insurer's obligation by
870 reference to a portfolio of assets that is not owned or possessed by the
871 insurance company; (L) an obligation that does not arise under the
872 express written terms of the policy or contract issued by the insurer to
873 the contract owner or policy owner, including, but not limited to: (i) A
874 claim based on marketing materials; (ii) a claim based on side letters,

875 riders or other documents that were issued by the insurer without
876 meeting applicable policy form filing or approval requirements; (iii) a
877 misrepresentation of or regarding policy benefits; (iv) an extra-
878 contractual claim; or (v) a claim for penalties or consequential or
879 incidental damages; (M) a contractual agreement that establishes the
880 member insurer's obligations to provide a book value accounting
881 guaranty for defined contribution benefit plan participants by
882 reference to a portfolio of assets that is owned by the benefit plan or its
883 trustee, which in each case is not an affiliate of the member insurer;
884 [and] (N) a portion of a policy or contract to the extent it provides for
885 interest or other changes in value to be determined by the use of an
886 index or other external reference stated in the policy or contract, but
887 which have not been credited to the policy or contract, or as to which
888 the policy or contract owner's rights are subject to forfeiture, as of the
889 date the member insurer becomes an impaired or insolvent insurer
890 under sections 38a-858 to 38a-875, inclusive, as amended by this act,
891 whichever is earlier. If a policy's or contract's interest or changes in
892 value are credited less frequently than annually, then for purposes of
893 determining the values that have been credited and are not subject to
894 forfeiture under this subparagraph, the interest or change in value
895 determined by using the procedures defined in the policy or contract
896 shall be credited as if the contractual date of crediting interest or
897 changing values was the date of impairment or insolvency, whichever
898 is earlier, and shall not be subject to forfeiture; and (O) a policy or
899 contract providing any hospital, medical, prescription drugs or other
900 health care benefits pursuant to Part C or Part D of Subchapter XVIII of
901 42 USC 7, as amended from time to time, commonly known as
902 Medicare Parts C and D, or any regulations issued thereunder.

903 [(g)] (e) The benefits for which the association may become liable
904 shall in no event exceed the lesser of:

905 (1) The contractual obligations for which the insurer is liable or
906 would have been liable if it were not an impaired or insolvent insurer,
907 or

908 (2) (A) [with] With respect to any one life, regardless of the number
909 of policies or contracts: (i) Five hundred thousand dollars in life
910 insurance death benefits, but no more than five hundred thousand
911 dollars in net cash surrender and net cash withdrawal values for life
912 insurance; (ii) five hundred thousand dollars in health insurance
913 benefits, including, but not limited to, any net cash surrender and net
914 cash withdrawal values; (iii) five hundred thousand dollars in the
915 present value of annuity benefits, including, but not limited to, net
916 cash surrender and net cash withdrawal values;

917 (B) [with] With respect to each individual participating in a
918 governmental retirement plan established under Section 401, 403(b) or
919 457 of the United States Internal Revenue Code of 1986, or any
920 subsequent internal revenue code of the United States, as amended
921 from time to time, covered by an unallocated annuity contract or the
922 beneficiaries of each such individual if deceased, in the aggregate, five
923 hundred thousand dollars in present value annuity benefits, including,
924 but not limited to, net cash surrender and net cash withdrawal values;

925 (C) [with] With respect to each payee of a structured settlement
926 annuity, or beneficiary or beneficiaries of the payee if deceased, five
927 hundred thousand dollars in present value annuity benefits, in the
928 aggregate, including, but not limited to, net cash surrender and net
929 cash withdrawal values, if any, provided in no event shall the
930 association be liable to expend (i) more than the five hundred
931 thousand dollars in the aggregate with respect to any one individual
932 under this subparagraph and subparagraphs (A) [,] and (B) [and (C)]
933 of this subdivision, and (ii) with respect to one owner of multiple
934 nongroup policies of life insurance, whether the policy owner is an
935 individual, firm, corporation or other person, and whether the persons
936 insured are officers, managers, employees or other persons, more than
937 five million dollars in benefits, regardless of the number of policies and
938 contracts held by the owner;

939 (D) [with] With respect to either (i) one contract owner provided
940 coverage under subparagraph (B) of subdivision (2) of subsection [(b)]

941 (a) of this section, or (ii) one plan sponsor whose plans own directly or
942 in trust one or more unallocated annuity contracts not included in
943 subparagraph (B) of this subdivision, [(2) of this subsection,] five
944 million dollars in benefits regardless of the number of contracts with
945 respect to the contract owner or plan sponsor, except that in the case
946 where one or more unallocated annuity contracts are covered contracts
947 under sections 38a-858 to 38a-875, inclusive, as amended by this act,
948 and are owned by a trust or other entity for the benefit of two or more
949 plan sponsors, coverage shall be afforded by the association if the
950 largest interest in the trust or entity owning the contract or contracts is
951 held by a plan sponsor whose principal place of business is in this state
952 and in no event shall the association be obligated to cover more than
953 five million dollars in benefits with respect to all such unallocated
954 contracts.

955 [(h)] (f) The limits set forth in subsection [(g)] (e) of this section are
956 limits on the benefits for which the association is obligated before
957 taking into account either the association's subrogation and
958 assignment rights or the extent to which those benefits could be
959 provided out of the assets of the impaired or insolvent insurer that are
960 attributable to covered policies. The costs of the association's
961 obligations under sections 38a-858 to 38a-875, inclusive, as amended
962 by this act, may be met by the use of assets attributable to covered
963 policies or reimbursed to the association pursuant to the association's
964 subrogation and assignment rights.

965 [(i)] (g) In performing its obligation to provide coverage under
966 section 38a-865, as amended by this act, the association shall not be
967 required to guarantee, assume, reinsure or perform, or cause to be
968 guaranteed, assumed, reinsured or performed, the contractual
969 obligations of the insolvent or impaired insurer under a covered policy
970 or contract that does not materially affect the economic value or
971 economic benefit of the covered policy or contract.

972 Sec. 10. Section 38a-863 of the general statutes is repealed and the
973 following is substituted in lieu thereof (*Effective October 1, 2011*):

974 (a) There is created a nonprofit legal entity to be known as the
975 Connecticut Life and Health Insurance Guaranty Association. All
976 member insurers shall be and remain members of the association as a
977 condition of their authority to transact insurance in this state. The
978 association shall perform its functions under the plan of operation
979 established and approved under section 38a-867, as amended by this
980 act, and shall exercise its powers through a board of directors
981 established under section 38a-864, as amended by this act. For
982 purposes of administration and assessment, the association shall
983 maintain two accounts: (1) The life insurance and annuity account
984 which includes the following subaccounts: (A) Life insurance account;
985 (B) annuity account which shall include, but is not limited to, annuity
986 contracts owned by a governmental retirement plan, or its trustee,
987 established under Section 401, 403(b) or 457 of the Internal Revenue
988 Code of 1986, or any subsequent corresponding internal revenue code
989 of the United States, as from time to time amended, but shall otherwise
990 exclude unallocated annuities; and (C) unallocated annuity account
991 which shall exclude contracts owned by a governmental retirement
992 benefit plan, or its trustee, established under Section 401, 403(b) or 457
993 of the Internal Revenue Code of 1986, or any subsequent
994 corresponding internal revenue code of the United States, as from time
995 to time amended; and (2) the health insurance account.

996 (b) The association shall come under the immediate supervision of
997 the commissioner and shall be subject to the applicable provisions of
998 the insurance laws of this state. Meetings or records of the association
999 may be opened to the public upon a majority vote of the board of
1000 directors of the association.

1001 Sec. 11. Section 38a-864 of the general statutes is repealed and the
1002 following is substituted in lieu thereof (*Effective October 1, 2011*):

1003 (a) The board of directors of the association shall consist of not less
1004 than five [nor] or more than nine members, two of which shall be
1005 persons representing the public and the remainder which shall be
1006 persons representing insurers, serving terms as established in the plan

1007 of operation under section 38a-867, as amended by this act.

1008 (1) The [members of the board] directors of said board who
1009 represent insurers shall be selected by member insurers and subject to
1010 the approval of the commissioner. Vacancies on the board for such
1011 directors shall be filled for the remaining period of the term [in the
1012 manner described in the plan of operation] by a majority vote of the
1013 remaining directors, subject to the approval of the commissioner. [To
1014 select the initial board of directors, and initially organize the
1015 association, the commissioner shall give notice to all member insurers
1016 of the time and place of the organizational meeting. In determining
1017 voting rights at the organizational meeting each member insurer shall
1018 be entitled to one vote in person or by proxy. If the board of directors
1019 is not selected within sixty days after notice of the organizational
1020 meeting, the commissioner may appoint the initial members.]

1021 [(b)] In approving selections [or in appointing members] to the
1022 board, the commissioner shall consider, among other things, whether
1023 all member insurers are fairly represented.

1024 (2) The directors of said board who represent the public shall be
1025 appointed by the commissioner. Vacancies on the board for such
1026 directors shall be filled for the remaining period of the term by the
1027 commissioner. No officer, director or employee of an insurer or any
1028 person engaged in the business of insurance shall be eligible to serve as
1029 a director who represents the public.

1030 [(c) Members] (b) The directors of the board may be reimbursed
1031 from the assets of the association for expenses incurred by them as
1032 members of the board of directors but [members of the board] the
1033 directors shall not otherwise be compensated by the association for
1034 their services.

1035 Sec. 12. Subsection (d) of section 38a-865 of the general statutes is
1036 repealed and the following is substituted in lieu thereof (*Effective*
1037 *October 1, 2011*):

1038 (d) Premiums due for coverage after entry of an order of liquidation
1039 of an insolvent insurer shall belong to and be payable at the direction
1040 of the association, and the association shall be liable for unearned
1041 premiums due to policy or contract owners arising after the date of the
1042 entry of the order. Upon request by the liquidator of an insolvent
1043 insurer, the association shall provide to such liquidator a report
1044 regarding such premiums that the association has collected.

1045 Sec. 13. Subsection (n) of section 38a-865 of the general statutes is
1046 repealed and the following is substituted in lieu thereof (*Effective*
1047 *October 1, 2011*):

1048 (n) (1) (A) At any time within [one year after the date on which the
1049 association becomes responsible for the obligations of a member
1050 insurer, which date shall be deemed the coverage date] one hundred
1051 eighty days after the date of the entry of the order of liquidation, the
1052 association may elect to [succeed to] assume the rights and obligations
1053 of the [member] insolvent insurer [that accrue on or after the coverage
1054 date and] that relate to [contracts] policies or annuities covered, in
1055 whole or in part, by the association, in each case under any one or
1056 more [indemnity] reinsurance [agreements] contracts entered into by
1057 the [member] insolvent insurer [as a ceding insurer] and its reinsurers
1058 and selected by the association. [, except that the association may not
1059 exercise an election with respect to a reinsurance agreement if the
1060 receiver, rehabilitator or liquidator of a member insurer has previously
1061 and expressly disaffirmed the reinsurance agreement.] Any such
1062 assumption shall be effective as of the date of the entry of the order of
1063 liquidation. The election shall be effected by a notice to the receiver [,
1064 rehabilitator or liquidator] and to the affected reinsurers.

1065 (B) To facilitate the earliest practicable decision by the association
1066 whether to assume any reinsurance contracts entered into by the
1067 insolvent insurer and to protect the financial position of the estate of
1068 the insolvent insurer, upon request by the association, the receiver and
1069 each reinsurer of the insolvent insurer shall make available as soon as
1070 possible after the commencement of formal delinquency proceedings

1071 (i) copies of reinsurance contracts in force and all related files and
1072 records relevant to the determination of whether such contracts should
1073 be assumed, and (ii) notices of any defaults under such reinsurance
1074 contracts or any known event or condition that, with the passage of
1075 time, could become a default under such reinsurance contracts.

1076 (C) [If the association makes an election, then subparagraphs (A) to
1077 (D), inclusive, of this subdivision shall apply with respect to the
1078 agreements selected] For reinsurance contracts assumed by the
1079 association pursuant to this subsection:

1080 [(A)] (i) The association shall be responsible for all unpaid
1081 premiums due under the [agreements] reinsurance contracts for
1082 periods before, on and after the [coverage] date [,] of the entry of the
1083 order of liquidation and shall be responsible for the performance of all
1084 other obligations to be performed after the [coverage] date [,] of the
1085 entry of the order of liquidation, that relate in each case [which relate]
1086 to [contracts] policies or annuities covered, in whole or in part, by the
1087 association. The association may charge [contracts] policies or
1088 annuities covered in part by the association, through reasonable
1089 allocation methods, the costs for reinsurance in excess of the
1090 obligations of the association, [. (B)] and shall provide notice and an
1091 accounting of such charges to the receiver;

1092 (ii) The association shall be entitled to any amounts payable by the
1093 reinsurer under the [agreements] reinsurance contracts with respect to
1094 losses or events that occur in periods after the [coverage] date of the
1095 entry of the order of liquidation and that relate to [contracts] policies
1096 or annuities covered, [by the association] in whole or in part, [and] by
1097 the association, provided upon the association's receipt of any such
1098 [amount] amounts, the association shall pay any beneficiary of a policy
1099 or [contract under] annuity on account of which [the association] an
1100 amount was paid, [only] a portion of the [policy or contract] amount
1101 equal to the lesser of: [(i)] (I) The amount received by the association;
1102 [that exceeds the benefits paid the beneficiary under the policy, less
1103 (ii)] or (II) the amount received by the association that exceeds the

1104 benefits paid by the association on account of the policy or [contract]
1105 annuity, less the retention of the [impaired or insolvent member]
1106 insurer applicable to the loss or event; [.]

1107 [(C)] (iii) Not later than thirty days after the association's election,
1108 the association and each [indemnity] reinsurer under contracts
1109 assumed by the association shall calculate the net balance due to or
1110 from the association under each reinsurance [agreement] contract as of
1111 the date of the association's election [, giving] with respect to policies
1112 or annuities covered, in whole or in part, by the association, which
1113 calculation shall give full credit to all items paid by [either] the
1114 [member] insurer or its receiver [, rehabilitator or liquidator or the
1115 indemnity reinsurer during the period between the coverage date and]
1116 or the reinsurer prior to the date of the association's election. [Either
1117 the association or indemnity] The reinsurer shall pay the [net] receiver
1118 any amounts due for losses or events that occurred in periods prior to
1119 the date of the entry of the order of liquidation, subject to any set off
1120 for premiums unpaid for periods prior to such date, and the
1121 association or the reinsurer shall pay any remaining balance due the
1122 other, in each case not later than five days after the completion of the
1123 calculation. [If the receiver, rehabilitator or liquidator] Any dispute
1124 over the amount due to either the association or the reinsurer shall be
1125 resolved by arbitration pursuant to the terms of the affected
1126 reinsurance contract, or if the contract contains no arbitration clause, as
1127 otherwise provided by law. If the receiver has received any amounts
1128 due the association pursuant to subparagraph [(B)] (C)(ii) of this
1129 subdivision, the receiver [, rehabilitator or liquidator] shall remit the
1130 same to the association as promptly as practicable; [.]

1131 [(D)] (iv) If the association or the receiver on the association's behalf
1132 pays, not later than sixty days after the election, [pays] the premiums
1133 due for periods before, on and after the [coverage] election date that
1134 relate to [contracts] policies or annuities covered, [by the association]
1135 in whole or in part, by the association, the reinsurer shall not [be
1136 entitled to] terminate the reinsurance [agreements] contracts for
1137 nonpayment of premium insofar as the [agreements] reinsurance

1138 contracts relate to [contracts] policies or annuities covered, [by the
1139 association] in whole or in part, by the association and shall not [be
1140 entitled to] set off any unpaid [premium] amounts due [for periods
1141 prior to the coverage date] under other contracts or unpaid amounts
1142 due from parties other than the association against amounts due the
1143 association.

1144 (2) [If the association transfers its obligations to another insurer, and
1145 if the association and the other insurer agree, the other insurer shall
1146 succeed to the rights and obligations of the association under
1147 subdivision (1) of this subsection, provided: (A) The indemnity
1148 reinsurance agreements shall automatically terminate for new
1149 reinsurance unless the indemnity reinsurer and the other insurer agree
1150 to the contrary; and (B) the association's obligation to pay the
1151 beneficiary pursuant to subparagraph (B) of subdivision (1) of this
1152 subsection shall no longer apply on or after the date the indemnity
1153 reinsurance agreement is transferred to the third party insurer. This
1154 subdivision shall not apply if the association has previously expressly
1155 determined in writing that it will not exercise the election referred to in
1156 subdivision (1) of this subsection.] (A) During the period from the date
1157 of the entry of the order of liquidation until the election date, or if there
1158 is no election, until one hundred eighty days after the date of the entry
1159 of the order of liquidation, (i) neither the association nor the reinsurer
1160 shall have any rights or obligations under reinsurance contracts that
1161 the association has the right to assume under subdivision (1) of this
1162 subsection, and (ii) the association, the receiver and the reinsurer shall,
1163 to the extent practicable, provide to each other data and records
1164 reasonably requested by each. Upon the election by the association to
1165 assume a reinsurance contract, the rights and obligations of the
1166 association and the reinsurer shall be governed by subdivision (1) of
1167 this subsection.

1168 (B) If the association does not elect to assume a reinsurance contract
1169 by the election date set forth in subdivision (1) of this subsection, the
1170 association shall have no rights or obligations with respect to such
1171 contract.

1172 (C) When the receiver transfers policies or annuities or covered
1173 obligations thereto to an assuming insurer, the association may
1174 transfer to such insurer any reinsurance contract it assumed on such
1175 policies or annuities pursuant to subdivision (1) of this section, subject
1176 to the following: (i) The reinsurance contract shall not cover any new
1177 policies or annuities in addition to those transferred unless otherwise
1178 agreed by the reinsurer and the assuming insurer; (ii) the association
1179 shall not be obligated under subdivision (1) of this subsection with
1180 respect to losses or events arising on or after the effective date of the
1181 transfer of the reinsurance contract; and (iii) the association provides
1182 written notice, return receipt requested, to the affected reinsurer not
1183 less than thirty days prior to the effective date of the transfer of the
1184 reinsurance contract.

1185 (3) The provisions of this subsection shall supersede the provisions
1186 of any law of this state or of any affected reinsurance [agreement]
1187 contract that provides for or requires any payment of reinsurance
1188 proceeds on account of losses or events that occur in periods on and
1189 after the [coverage] date of the entry of the order of liquidation to the
1190 receiver [, liquidator or rehabilitator] of the insolvent [member] insurer
1191 or to any other person. The receiver [, rehabilitator or liquidator] shall
1192 remain entitled to any amount payable by the reinsurer under the
1193 reinsurance [agreement] contract with respect to losses or events that
1194 occur in periods prior to the [coverage] date of the entry of the order of
1195 liquidation, subject to applicable [setoff] set off provisions.

1196 (4) Except as otherwise expressly provided in this [subsection]
1197 section, nothing in this [section] subsection shall alter or modify the
1198 terms and conditions of [the indemnity] any reinsurance [agreements
1199 of the insolvent member insurer] contract. Nothing in this section shall
1200 abrogate or limit any rights of any reinsurer to claim that it is entitled
1201 to rescind a reinsurance [agreement] contract. Nothing in this section
1202 shall (A) give a policy owner or beneficiary an independent cause of
1203 action against [an indemnity] a reinsurer that is not otherwise set forth
1204 in the [indemnity] reinsurance [agreement] contract, (B) limit or affect
1205 the association's right as a creditor of the estate of the insolvent

1206 insurer, or (C) apply to reinsurance contracts covering property or
1207 casualty risks.

1208 Sec. 14. Subsections (a) to (c), inclusive, of section 38a-866 of the
1209 general statutes are repealed and the following is substituted in lieu
1210 thereof (*Effective October 1, 2011*):

1211 (a) For the purpose of providing the funds necessary to carry out the
1212 powers and duties of the association, the board of directors shall assess
1213 the member insurers, separately for each account, at such times and for
1214 such amounts as the board finds necessary. The association shall
1215 establish a due date for each assessment which shall be at least thirty
1216 days after the association has provided the member notice of the
1217 assessment. Each member insurer shall pay interest on any late
1218 payment at the rate of one per cent per month, or any portion thereof,
1219 from the due date to the date of payment.

1220 (b) There shall be two classes of assessments, as follows: (1) Class A
1221 assessments shall be [made] authorized and called for the purpose of
1222 meeting administrative and legal costs and other general expenses not
1223 related to a particular impaired or insolvent insurer; (2) Class B
1224 assessments shall be authorized and called to the extent necessary to
1225 carry out the powers and duties of the association under section 38a-
1226 865 with regard to an impaired or insolvent insurer.

1227 (c) (1) The amount of any Class A assessment shall be determined
1228 by the board and may be authorized and called on a pro-rata or non-
1229 pro-rata basis. If an assessment is made on a pro-rata basis, the board
1230 may provide that the assessment be credited against future Class B
1231 assessments. On and after January 1, 2012, the total of all non-pro-rata
1232 assessments shall not exceed three hundred dollars per member
1233 insurer per calendar year. The amount of any Class B assessment shall
1234 be allocated for assessment purposes among the accounts pursuant to
1235 an allocation formula which may be based on the premiums or
1236 reserves of the impaired or insolvent insurer or any other standard that
1237 the board, in its sole discretion, deems as being fair and reasonable
1238 under the circumstances.

1239 (2) Class B assessments against member insurers for each account
1240 and subaccount shall be in the proportion that the premiums received
1241 on business in this state by each assessed member insurer on policies
1242 or contracts covered by each account for the three most recent calendar
1243 years for which information is available preceding the year in which
1244 the insurer became insolvent or, in the case of an assessment with
1245 respect to an impaired insurer, the three most recent calendar years for
1246 which information is available preceding the year in which the insurer
1247 became impaired bear to such premiums received on business in this
1248 state for those calendar years by all assessed member insurers.

1249 (3) Assessments for funds to meet the requirements of the
1250 association with respect to an impaired or insolvent insurer shall not
1251 be authorized or called until necessary to implement the purposes of
1252 sections 38a-858 to 38a-875, inclusive. Classification of assessments
1253 under subsection (b) of this section and computation of assessments
1254 under this subsection shall be made with a reasonable degree of
1255 accuracy, recognizing that exact determinations may not always be
1256 possible. The association shall notify each member insurer of its
1257 anticipated pro-rata share of an authorized assessment that is not yet
1258 called not later than one hundred eighty days after the association
1259 authorizes the assessment.

1260 Sec. 15. Subsection (h) of section 38a-866 of the general statutes is
1261 repealed and the following is substituted in lieu thereof (*Effective*
1262 *October 1, 2011*):

1263 (h) (1) Each insurer paying an assessment under [sections 38a-858 to
1264 38a-875, inclusive,] this section may offset, for an assessment paid in
1265 the income year commencing prior to January 1, 2012, one hundred per
1266 cent and for an assessment paid in income years commencing on or
1267 after January 1, 2012, fifty per cent of the amount of such assessment
1268 against its premium tax liability to this state under chapter 207. Such
1269 offset shall be taken over a period of the five successive tax years
1270 following the year of payment of the assessment, at the rate of twenty
1271 per cent per year of [the assessment paid to the association] such offset.

1272 Each insurer to which has been refunded by the association, pursuant
1273 to subsection (f) of this section, all or a portion of an assessment
1274 previously paid to the association by the insurer shall be required to
1275 pay to the Department of Revenue Services an amount equal to the
1276 total amount that has been claimed as an offset against the premiums
1277 tax liability on the premiums tax return or returns, as the case may be,
1278 filed by such insurer and that is attributable to such refunded
1279 assessment, provided the amount required to be paid to said
1280 department shall not exceed the amount of the refunded assessment. If
1281 the amount of the refunded assessment exceeds the total amount that
1282 has been claimed as an offset against the premiums tax liability on the
1283 premiums tax return or returns filed by such insurer and that is
1284 attributable to such refunded assessment, such excess may not be
1285 claimed as an offset against the premiums tax liability on a premiums
1286 tax return or returns filed by such insurer or, if the offset has been
1287 transferred to another person pursuant to subdivision (2) of this
1288 subsection, by such other person. For purposes of this subdivision, if
1289 the offset has been transferred to another person pursuant to
1290 subdivision (2) of this subsection, the total amount that has been
1291 claimed as an offset against the premiums tax liability on the
1292 premiums tax return or returns filed by such insurer includes the total
1293 amount that has been claimed as an offset against the premiums tax
1294 liability on the premiums tax return or returns filed by such other
1295 person. The association shall promptly notify the Commissioner of
1296 Revenue Services of the name and address of the insurers to which
1297 such refunds have been made, the amount of such refunds, and the
1298 date on which such refunds were mailed to each such insurer. If the
1299 amount that an insurer is required to pay to the Department of
1300 Revenue Services has not been so paid on or before the forty-fifth day
1301 after the date of mailing of such refunds, the insurer shall be liable for
1302 interest on such amount at the rate of one per cent per month, or
1303 fraction thereof, from such forty-fifth day to the date of payment.

1304 (2) An insurer, in this subdivision called "the transferor", may
1305 transfer any offset provided under subdivision (1) of this subsection to
1306 an affiliate, as defined in section 38a-1, of the transferor. Any such

1307 transfer of the offset by the transferor, and any subsequent transfer or
1308 transfers of the same offset, shall not affect the obligation of the
1309 transferor to pay to the Department of Revenue Services any sums
1310 which are acquired by refund from the association pursuant to
1311 subsection (f) of this section and which are required to be paid to the
1312 Department of Revenue Services pursuant to subdivision (1) of this
1313 subsection. Such offset may be taken by any transferee only against the
1314 transferee's premium tax liability to this state under chapter 207. The
1315 Commissioner of Revenue Services shall not allow such offset to a
1316 transferee against its premium tax liability unless the transferor, the
1317 affiliate to which the offset was originally transferred, each subsequent
1318 transferor and each subsequent transferee have filed such information
1319 as may be required on forms provided by said commissioner with
1320 respect to any such transfer or transfers on or before the due date of
1321 the premium tax return on which such offset would have been taken
1322 by the transferor, if no transfer had been made by the transferor.

1323 Sec. 16. Subsection (c) of section 38a-867 of the general statutes is
1324 repealed and the following is substituted in lieu thereof (*Effective*
1325 *October 1, 2011*):

1326 (c) The plan of operation shall, in addition to requirements
1327 enumerated elsewhere in sections 38a-858 to 38a-875, inclusive, as
1328 amended by this act: (1) Establish procedures for handling the assets of
1329 the association; (2) establish the amount and method of reimbursing
1330 members of the board of directors under section 38a-864, as amended
1331 by this act; (3) establish regular places and times for meetings
1332 including telephone conference calls of the board of directors; (4)
1333 establish procedures for records to be kept of all financial transactions
1334 of the association, its agents and the board of directors; (5) establish the
1335 procedures whereby selections for the board of directors will be made
1336 and submitted to the commissioner; (6) establish any additional
1337 procedures for assessments under section 38a-866, as amended by this
1338 act; (7) contain additional provisions necessary or proper for the
1339 execution of the powers and duties of the association.

1340 Sec. 17. Section 38a-868 of the general statutes is repealed and the
1341 following is substituted in lieu thereof (*Effective October 1, 2011*):

1342 (a) In addition to the duties and powers enumerated elsewhere in
1343 sections 38a-858 to 38a-875, inclusive, as amended by this act, [(a)
1344 The] the commissioner shall: (1) Notify the board of directors of the
1345 existence of an impaired insurer not later than three days after a
1346 determination of impairment is made or he receives notice of
1347 impairment; (2) upon request of the board of directors, provide the
1348 association with a statement of the premiums in the appropriate states
1349 for each member insurer; and (3) when an impairment is declared and
1350 the amount of the impairment is determined, serve a demand upon the
1351 impaired insurer to make good the impairment within a reasonable
1352 time. Notice to the impaired insurer shall constitute notice to its
1353 shareholders, if any. The failure of the insurer to promptly comply
1354 with such demand shall not excuse the association from the
1355 performance of its powers and duties under sections 38a-858 to 38a-
1356 875, inclusive, as amended by this act. [; (4) in any liquidation or
1357 rehabilitation proceeding involving a domestic insurer, be appointed
1358 as the liquidator or rehabilitator. If a foreign or alien member insurer is
1359 subject to a liquidation proceeding in its domiciliary jurisdiction or
1360 state of entry, the commissioner shall be appointed conservator.]

1361 (b) The commissioner may suspend or revoke, after notice and
1362 hearing, the certificate of authority issued by this state to any member
1363 insurer that fails to pay an assessment when due or fails to comply
1364 with the plan of operation. As an alternative, the commissioner may
1365 levy a forfeiture on any member insurer that fails to pay an assessment
1366 when due. Such forfeiture shall not exceed five per cent of the unpaid
1367 assessment per month, but no forfeiture shall be less than five hundred
1368 dollars per month.

1369 (c) Any final action of the board of directors or the association may
1370 be appealed to the commissioner by any member insurer if such
1371 appeal is taken within thirty days of the final action being appealed.
1372 Any final action or order of the commissioner shall be subject to

1373 judicial review in the superior court for the judicial district of Hartford.

1374 (d) The liquidator, rehabilitator or conservator of any impaired or
1375 insolvent insurer may notify all interested persons of the effect of
1376 sections 38a-858 to 38a-875, inclusive, as amended by this act.

1377 Sec. 18. Section 38a-871 of the general statutes is repealed and the
1378 following is substituted in lieu thereof (*Effective October 1, 2011*):

1379 (a) Nothing in sections 38a-858 to 38a-875, inclusive, as amended by
1380 this act, shall be construed to reduce the liability for unpaid
1381 assessments of the insureds of an impaired or insolvent insurer
1382 operating under a plan with assessment liability.

1383 (b) Records shall be kept of all negotiations and meetings in which
1384 the association or its representatives are involved to discuss the
1385 activities of the association in carrying out its powers and duties under
1386 section 38a-865, as amended by this act. Records of such negotiations
1387 or meetings shall be made public only upon the termination of a
1388 liquidation, rehabilitation, or conservation proceeding involving the
1389 impaired or insolvent insurer, upon the termination of the impairment
1390 or insolvency of the insurer, or upon the order of a court of competent
1391 jurisdiction. Nothing in this subsection shall limit the duty of the
1392 association to render a report of its activities under section 38a-872.

1393 (c) For the purpose of carrying out its obligations under sections
1394 38a-858 to 38a-875, inclusive, as amended by this act, the association
1395 shall be deemed to be a creditor of the impaired or insolvent insurer to
1396 the extent of assets attributable to covered policies reduced by any
1397 amounts to which the association is entitled as subrogee pursuant to
1398 subdivision [(i)] (k) of section 38a-865. All assets of the impaired or
1399 insolvent insurer attributable to covered policies shall be used to
1400 continue all covered policies and pay all contractual obligations of the
1401 impaired or insolvent insurer as required by sections 38a-858 to 38a-
1402 875, inclusive, as amended by this act. Assets attributable to covered
1403 policies, as used in this subsection, is that proportion of the assets
1404 which the reserves that should have been established for such policies

1405 bear to the reserve that should have been established for all policies of
1406 insurance written by the impaired or insolvent insurer.

1407 (d) As a creditor of the impaired or insolvent insurer pursuant to
1408 subsection (c) of this section, the association shall be entitled to receive
1409 from time to time a disbursement of assets, as such assets become
1410 available, from the marshaled assets of the impaired or insolvent
1411 insurer, as credits against the contractual obligations of the association
1412 under sections 38a-858 to 38a-875, inclusive, as amended by this act. If
1413 the liquidator has not made an application to the receivership court,
1414 within one hundred twenty days after a final determination of
1415 insolvency of a member insurer, for the approval of a proposal to
1416 disburse assets to the association, the association may make an
1417 application to such court for the approval of its own proposal to
1418 disburse such assets.

1419 [(d)] (e) (1) Prior to the termination of any liquidation, rehabilitation
1420 or conservation proceeding, the court may take into consideration the
1421 contributions of the respective parties, including the association, the
1422 shareholders and [policyowners] policy owners of the impaired or
1423 insolvent insurer, and any other party with a bona fide interest, in
1424 making an equitable distribution of the ownership rights of such
1425 impaired or insolvent insurer. In such a determination, consideration
1426 shall be given to the welfare of the [policyholders] policy owners of the
1427 continuing or successor insurer. (2) No distribution to stockholders, if
1428 any, of an impaired or insolvent insurer shall be made until and unless
1429 the total amount of [assessments levied by] valid claims of the
1430 association for funds expended by the association to carry out its
1431 duties under section 38a-865, as amended by this act, with respect to
1432 such insurer, plus interest at a rate to be determined by the liquidator,
1433 has been fully recovered by the [commission] association.

1434 [(e) It shall be a prohibited unfair trade practice and a violation of
1435 section 38a-815 for any person to make use in any manner of the
1436 protection afforded by sections 38a-858 to 38a-875, inclusive, in the
1437 solicitation, negotiation, procurement or effectuation of insurance

1438 provided, this subsection shall not apply to the distribution of any
1439 publication approved by the commissioner and describing the general
1440 purposes and current limitations of sections 38a-858 to 38a-874,
1441 inclusive. Violations of this section shall be subject to the provisions of
1442 section 38a-817.]

1443 (f) (1) [If an order for liquidation or rehabilitation of an insurer
1444 domiciled in this state has been entered, the receiver appointed under
1445 such order shall have a right to recover on behalf of the insurer, from
1446 any affiliate that controlled it, the amount of distributions, other than
1447 stock dividends paid by the insurer on its capital stock, made at any
1448 time during the five years preceding the petition for liquidation or
1449 rehabilitation subject to the limitations of subdivisions (2) to (4),
1450 inclusive. (2) No such dividend shall be recoverable if the insurer
1451 shows that when paid the distribution was lawful and reasonable, and
1452 that the insurer did not know and could not reasonably have known
1453 that the distribution might adversely affect the ability of the insurer to
1454 fulfill its contractual obligations. (3) Any person who was an affiliate
1455 that controlled the insurer at the time the distributions were paid shall
1456 be liable up to the amount of distributions he received. Any person
1457 who was an affiliate that controlled the insurer at the time the
1458 distributions were declared shall be liable up to the amount of
1459 distributions he would have received if they had been paid
1460 immediately. If two persons are liable with respect to the same
1461 distributions, they shall be jointly and severally liable. (4) The
1462 maximum amount recoverable under this subsection shall be the
1463 amount needed in excess of all other available assets of the impaired
1464 insurer to pay the contractual obligations of the impaired insurer. (5) If
1465 any person liable under subdivision (3) of this subsection is insolvent,
1466 all its affiliates that controlled it at the time the dividend was paid shall
1467 be jointly and severally liable for any resulting deficiency in the
1468 amount recovered from the insolvent affiliate.] No person, including
1469 an insurer, agent or affiliate of an insurer, shall make, publish,
1470 disseminate or place before the public, or cause directly or indirectly to
1471 be made, published, disseminated or placed before the public, in any
1472 form, manner or method any written or oral advertisement,

1473 announcement or statement that uses the existence of the association to
1474 sell, solicit or induce the purchase of any insurance covered by the
1475 association pursuant to sections 38a-858 to 38a-875, inclusive, as
1476 amended by this act.

1477 (2) (A) Not later than April 1, 2012, the association shall prepare and
1478 submit to the commissioner for the commissioner's approval a
1479 summary document that complies with subdivision (3) of this
1480 subsection and describes the general purposes of and restrictions
1481 imposed by sections 38a-858 to 38a-875, inclusive, as amended by this
1482 act. Upon the commissioner's approval of such document, the
1483 association shall notify its member insurers of the availability of such
1484 document and the requirements set forth in subparagraph (B) of this
1485 subdivision. The association shall revise such document as necessary
1486 to maintain accuracy.

1487 (B) Beginning sixty days after the date the commissioner approves
1488 the summary document, no member insurer shall deliver a policy or
1489 contract unless such document accompanies such policy or contract at
1490 the time of delivery to the policy or contract owner. Such document
1491 shall also be available upon request by a policy or contract owner.
1492 Such document shall not be a guarantee that the policy, contract or
1493 policy or contract owner is covered in the event of the impairment of
1494 insolvency of a member insurer. The failure of an insurer to provide
1495 such document shall not afford any rights to a policy or contract owner
1496 greater than those specified in sections 38a-858 to 38a-875, inclusive, as
1497 amended by this act.

1498 (3) The summary document set forth in subdivision (2) of this
1499 subsection shall contain a clear and conspicuous disclaimer on its face.
1500 The commissioner shall establish the form and content of such
1501 disclaimer, which shall include: (A) The name and address of the
1502 association and the Insurance Department; (B) a prominent warning
1503 that the association may not cover the policy or contract and if the
1504 association does cover the policy or contract, such coverage will be
1505 subject to substantial limitations and exclusions and conditioned on

1506 the policy or contract owner's continued residence in this state; (C) a
1507 statement of the types of coverage for which the association provides
1508 coverage; (D) a statement that the insurer and its agents are prohibited
1509 by law from using the existence of the association to sell, solicit or
1510 induce the purchase of any insurance; (E) a statement that the policy or
1511 contract owners should not rely on coverage under the association
1512 when selecting an insurer; (F) an explanation of the rights available to
1513 the policy or contract owner and the procedures for filing a complaint
1514 alleging a violation of any provision of sections 38a-858 to 38a-875,
1515 inclusive, as amended by this act; and (G) any other information as
1516 directed by the commissioner, including, but not limited to, sources for
1517 information about the financial condition of insurers, provided such
1518 information is not proprietary and is subject to disclosure pursuant to
1519 section 1-210.

1520 (4) A member insurer shall retain evidence of compliance, as
1521 established by the commissioner, with subdivision (2) of this
1522 subsection for as long as the policy or contract for which the summary
1523 document was delivered remains in effect.

1524 Sec. 19. Subparagraph (J) of subdivision (2) of section 38a-865 of the
1525 general statutes is repealed and the following is substituted in lieu
1526 thereof (*Effective October 1, 2011*):

1527 (J) When proceeding under this subdivision with respect to a policy
1528 or contract carrying guaranteed minimum interest rates, the
1529 association shall assure the payment or crediting of a rate of interest
1530 consistent with subparagraph (C) of subdivision (2) of subsection [(f)]
1531 (d) of section 38a-860, as amended by this act.

1532 Sec. 20. Subdivision (16) of section 38a-862 of the general statutes is
1533 repealed and the following is substituted in lieu thereof (*Effective*
1534 *October 1, 2011*):

1535 (16) "Premiums" means amounts or considerations, by whatever
1536 name called, received on covered policies or contracts less premiums,
1537 considerations and deposits returned thereon, and less dividends and

1538 experience credits thereon. "Premiums" does not include (A) any
 1539 amounts or considerations received for any policies or contracts or for
 1540 the portions of any policies or contracts for which coverage is not
 1541 provided under subsection [(f)] (d) of section 38a-860, as amended by
 1542 this act, except that assessable premium shall not be reduced on
 1543 account of subparagraph (C) of subdivision (2) of subsection [(f)] (d) of
 1544 section 38a-860, as amended by this act, relating to interest limitations,
 1545 and subdivision (2) of subsection [(g)] (e) of section 38a-860, as
 1546 amended by this act, relating to limitations with respect to any one
 1547 individual, any one participant and any one contract owner; provided
 1548 that "premiums" shall not include any premiums in excess of five
 1549 million dollars on any unallocated annuity contract not issued under a
 1550 governmental retirement benefit plan established under Section 401,
 1551 403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent
 1552 corresponding internal revenue code of the United States, as from time
 1553 to time amended, or (B) with respect to multiple nongroup policies of
 1554 life insurance owned by one owner, whether the policy owner is an
 1555 individual, firm, corporation or other person, and whether the persons
 1556 insured are officers, managers, employees or other persons, premiums
 1557 in excess of five million dollars with respect to such policies or
 1558 contracts, regardless of the number of policies or contracts held by the
 1559 owner;

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2011	38a-838
Sec. 2	October 1, 2011	38a-839
Sec. 3	October 1, 2011	38a-840
Sec. 4	October 1, 2011	38a-841
Sec. 5	October 1, 2011	38a-842
Sec. 6	October 1, 2011	38a-844
Sec. 7	October 1, 2011	38a-845
Sec. 8	October 1, 2011	38a-851
Sec. 9	October 1, 2011	38a-860
Sec. 10	October 1, 2011	38a-863
Sec. 11	October 1, 2011	38a-864
Sec. 12	October 1, 2011	38a-865(d)

Sec. 13	<i>October 1, 2011</i>	38a-865(n)
Sec. 14	<i>October 1, 2011</i>	38a-866(a) to (c)
Sec. 15	<i>October 1, 2011</i>	38a-866(h)
Sec. 16	<i>October 1, 2011</i>	38a-867(c)
Sec. 17	<i>October 1, 2011</i>	38a-868
Sec. 18	<i>October 1, 2011</i>	38a-871
Sec. 19	<i>October 1, 2011</i>	38a-865(2)(J)
Sec. 20	<i>October 1, 2011</i>	38a-862(16)

Statement of Legislative Commissioners:

Technical changes were made in sections 1(9)(A), 4(a)(4) and 13(n)(1)(C) for consistency with the drafting conventions of the general statutes.

INS *Joint Favorable Subst.-LCO*

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 12 \$	FY 13 \$
Insurance Department	GF - Reduces Potential Future Revenue Loss	Indeterminate	Indeterminate

Note: GF=General Fund

Municipal Impact: None

Explanation

This bill makes several changes to the Connecticut Insurance Guaranty Association Act (CIGA) and the Connecticut Life and Health Insurance Guaranty Association Act (CLHIGA).

This bill may reduce future revenue losses to the General Fund. Currently insurers are able to offset their premium tax liability by 100% of the payment made to insurance guaranty associations when there is an insolvency covered by the association. This bill reduces that offset to 50%. Therefore, when an insurance company becomes insolvent, there will be less of a general fund revenue loss associated with this offset. Any such reduction in revenue loss will be determined by the timing and cost of any future insolvency.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sHB 6509*****AN ACT CONCERNING THE CONNECTICUT INSURANCE GUARANTY ASSOCIATION ACT AND THE CONNECTICUT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.*****SUMMARY:**

This bill makes numerous changes to the Connecticut Insurance Guaranty Association Act (CIGA) and the Connecticut Life and Health Insurance Guaranty Association Act (CLHIGA) to conform to the National Association of Insurance Commissioners' (NAIC) Life and Health Insurance Guarantee Association Model Act. It:

1. requires both associations' board of directors to include two public representatives;
2. changes the associations' obligations, limitations, and exclusions;
3. reduces, from 100% to 50%, the premium tax liability offset for assessments paid to the associations;
4. allows CIGA member insurers to recoup the cost of assessments not subject to the premium tax liability offset in the rates they charge;
5. changes the limits on assessments the associations impose on their member insurers;
6. gives CIGA the right to (a) pursue and retain salvage and subrogation recoveries, (b) appoint and direct legal counsel for defense of covered claims, and (c) contest certain settlements and judgments entered into within 120 days before an insurer

- became insolvent;
7. makes changes to the requirement that insureds exhaust all other insurance coverage before making a claim against CIGA and reduces the amount CIGA pays on claims if an amount was recovered under another policy;
 8. gives the associations access to certain records pertaining to insolvent insurers;
 9. limits the type of action a CLHIGA member insurer may appeal to only a final action of the association or its board;
 10. expands the prohibition against using the protections afforded policyholders through CLHIGA to solicit or procure insurance;
 11. reduces the timeframe within which CLHIGA may elect to assume the rights of an insolvent insurer under a reinsurance contract;
 12. requires CLHIGA's member insurers to provide a summary document to all policy or contract owners that contains certain disclaimers about the association's purpose and limitations; and
 13. adds new definitions and revises others.

EFFECTIVE DATE: October 1, 2011

§§ 3 & 11 — BOARDS OF DIRECTORS

Composition

The bill requires that two members of both associations' board of directors represent the public and the remaining directors represent insurers. It specifically prohibits an officer, director, or employee of an insurer or any person in the insurance business from serving on either board as a public representative. Current law requires all members of each board to be selected by member insurers and approved by the commissioner.

By law both associations' board membership is limited to between five and nine members.

Appointments

By law, directors on both boards representing insurers must be selected by member insurers and approved by the insurance commissioner. But the bill, like current law, requires vacancies to be filled for the remaining period of the term by a majority vote of the remaining directors, including public directors, with the commissioner's approval.

The bill requires the insurance commissioner to appoint directors of each board representing the public and fill public director vacancies that occur for the remaining period of the term.

It allows the CIGA board of directors to declare a vacancy if any director fails to attend three consecutive meetings. The bill also deletes obsolete language regarding initial appointments to the CLHIGA board of directors.

Termination & Suspension of CIGA Board Members

The bill requires terminating an insurer's representative from the CIGA board if the insurer enters receivership. The termination is effective on the date the receivership order is entered.

It also allows the insurance commissioner to suspend a director from the board, pending the outcome of a department investigation or hearing, or the conclusion of a criminal proceeding. The commissioner may do so if he has reasonable cause to believe that the director (1) failed to disclose a known conflict of interest with respect to his or her board duties, (2) failed to take appropriate action based on a known conflict of interest with his or her board duties, or (3) has been indicted or charged with a felony.

If the director is an insurance representative, the bill allows the insurer the director represents to replace him or her before the investigation, hearing, or criminal proceeding ends.

The bill requires the commissioner to declare a vacancy if the investigation, hearing, or criminal proceeding substantiates the allegations or charges. The vacancy is filled as previously indicated.

§ 4 — CIGA COVERAGE OBLIGATIONS

The bill raises CIGA's coverage obligations. Under the bill, in the event of an insurer's insolvency, an insured has the right to recover from the association (1) all unearned premiums up to \$10,000 and (2) for all other claims, except workers compensation, up to \$500,000 if the insurer was declared insolvent on or after October 1, 2011.

Current law allows insureds to recover one-half the unearned premium up to \$2,000. For all other claims, except workers' compensation, the insured may recover up to \$400,000. Workers' compensation claims must be fully covered up to the policy limit.

The bill also eliminates the association's obligation to defend an insured after it has paid the lesser of (1) its covered claim obligation limit or (2) the applicable insurance policy limit.

§§ 4, 15 — PREMIUM TAX OFFSETS

For income years starting January 1, 2012, the bill reduces, from 100% to 50%, the amount of assessments an insurer pays to a state insurance guaranty association that it can use to offset (reduce) its premium tax liability. By law, the tax offset must be taken over a five-year period and may be transferred to an affiliate.

The bill defines an "affiliate" as a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or under common control with, an insolvent insurer on December 31 of the year immediately preceding the date the insurer became insolvent.

It defines "control" as the direct or indirect power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a contract for goods or nonmanagement services, or otherwise, unless that power is the result of a person's official position or corporate

office. Control must be presumed to exist if a person directly or indirectly owns, controls, or holds voting power or proxies representing, 10% or more of any voting securities of another person. This presumption is rebuttable by showing that control does not exist in fact.

§§ 4, 12 — PREMIUMS AND RATES

CIGA

The bill requires CIGA member insurers to include in rates and premiums it charges for applicable policies, an amount sufficient to recoup a sum equal to the assessment an insurer paid to the association less any amount (1) returned to the insurer by the association or (2) subject to a premium tax offset (see above). It specifies that premiums and rates must not be deemed excessive solely because they contain an additional amount reasonably calculated to recoup all assessments the member insurer paid to the association.

CLHIGA

The bill requires CLHIGA, at the request of a liquidator of an insolvent insurer, to provide the liquidator a report on premiums collected by CLHIGA for coverage.

§§ 4, 14 — ASSESSMENTS

CIGA

The bill limits the assessment levied on the “all other insurance account” of a CIGA member insurer to 2% in any year. Under current law, insurers may only be assessed on the premiums attributable to the kind of insurance giving rise to the claim if more than half the premiums the insurer received for the assessment year were for policies issued in the state for risks in the state.

By law, insurers must participate in and pay assessments to CIGA. Assessments are divided into three accounts: (1) workers’ compensation, (2) auto insurance, and (3) “all other insurance.”

CLHIGA

The bill specifies that class “A” assessments cover CLHIGA’s legal costs in addition to administrative costs and general expenses. And starting January 1, 2012, the bill limits class “A” assessment to \$300 per member in any one calendar year when made on a non-pro-rata basis. By law, CLHIGA assesses its member insurers to raise funds to fulfill its statutory obligations. The assessments are based on the amount of premiums members write in the state.

§ 4 — EXPANSION OF CIGA RIGHTS & DUTIES

Right To Salvage And Subrogation Recoveries

The law deems CIGA as the insolvent insurer with respect to its obligations on covered claims and gives it the rights, duties, and obligations of the insolvent insurer as if it had not become insolvent. The bill adds to CIGA’s powers the right to pursue and retain salvage and subrogation recoveries on covered claim obligations to the extent paid by the association. It specifies that the association is not deemed the insolvent insurer for purposes of conferring jurisdiction.

Right To Appoint And Direct Legal Counsel

The bill give CIGA the right to appoint and direct legal counsel retained under liability insurance policies to defend covered claims. Current law allows it to investigate, adjust, compromise, settle, and pay covered claims under its obligation and to deny all other claims.

Cooperation With Other Associations and Receivers

The bill requires CIGA to that it make all reasonable efforts, in cooperation with other similarly obligated or potentially obligated associations, or their authorized representatives, to cooperate with the receivers or the insolvent insurers’ authorized representatives in a uniform manner, including through the use of uniform data standards promulgated or approved by the NAIL.

It also allows CIGA to join one or more organizations comprised of other similar associations in other states and designate such an organization to act as a liaison for the association and, to the extent CIGA authorizes the organization, to bind the association to

agreements or settlements with receivers or authorized representatives of insolvent insurers. The bill defines an “association similar to the association” as any guarantee association, security fund, or other insolvency mechanism that affords protection similar to CIGA’s. It includes any property and casualty insolvency mechanism that obtains assessments or other contributions from insurers on a preinsolvency basis.

§ 4 — SETTLEMENTS AND JUDGMENTS

The bill gives CIGA the right to assert certain defenses, in addition to any available to the insurer, in an action to enforce a settlement, release, compromise, waiver, or judgment if the insolvent insurer or its insured was a party before the entry date of the order of liquidation.

The association may assert a defense that is not bound by any (1) settlement, release, compromise, or waiver executed by the insolvent insurer or its insured or (2) judgment entered against the insurer or its insured by consent or through failure to exhaust all appeals. The covered actions must have been executed or entered (1) within 120 days before the date of the liquidation order if the insurer or insured did not use reasonable care in executing or entering into it or did not pursue all reasonable appeals of an adverse judgment or (2) against an insurer or its insured based on default, fraud, collusion, or the insurer’s failure to defend it.

The bill also allows CIGA to assert any defenses or rights of offset against any settlement, release, compromise, waiver, or judgment executed by or entered against the insured.

If a court finds the association is not bound by a settlement, release, compromise, waiver, or judgment for any of the above reasons, the bill requires the court to set it aside and allow the association to defend any covered claim on its merits. The settlement, release, compromise, waiver, or judgment cannot be considered as evidence of liability or damages in connection with any claim brought against the association or any other party under the CIGA Act.

For a judgment regarding any covered claim under any decision, order, verdict or finding based on the default of the insolvent insurer or its failure to defend, the bill allows CIGA on its own behalf or on behalf of an insured of an insolvent insurer, to (1) apply to set aside or make a motion to open the judgment or finding with the same court or administrator and (2) defend the covered claim on its merits.

§ 6 — RECEIVERS OR LIQUIDATORS BOUND BY SETTLEMENTS UNDER CIGA

The bill eliminates the requirement that a receiver, liquidator, or statutory successor of an insolvent insurer accept CIGA claim determinations or settlements.

It also specifies that a reinsurer, insurer, insurance pool, underwriting association, HMO, hospital or medical service corporation, or self-insurer cannot assess any amount it is due against an insured of an insolvent insurer, except for amounts that exceed CIGA's obligation limits (see § 4 above).

§ 6 — RIGHT OF RECOVERY FROM A GOVERNMENTAL ENTITY

CIGA has the statutory right to recover from an insolvent insurer's (1) affiliates and (2) insureds whose net worth exceeds \$50 million, the amount of covered claims that CIGA paid on the affiliate's or insured's behalf. But CIGA cannot recover from a municipality. The bill extends this exemption to include all governmental entities. It limits affiliates to a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or under common control with, an insolvent insurer on December 31 of the year immediately preceding the date the insurer became insolvent.

§ 7 — EXHAUSTION OF RIGHTS BEFORE MAKING CLAIMS AGAINST CIGA

Exhaustion of Rights

By law, any person with a CIGA-covered claim must first exhaust his or her rights under an insurance policy before making a claim against CIGA. The bill instead requires a person to exhaust all coverage, including the right to a defense, provided by any other

insurance policy, regardless of whether the policy was issued by a member insurer, if the claim arises from the same facts, injury, or loss that gave rise to a covered claim against CIGA. It specifies that a claim arising from the same facts, injury, or loss must be considered to have occurred if another claim has arisen under a policy that provides liability coverage to a person who may be jointly and severally liable as a tortfeasor (wrongdoer) with the person insured under a policy issued by an insolvent insurer. This provision does not apply to any right an insured has under a (1) policy of an insolvent insurer or (2) life insurance policy.

Amounts Recovered Under Other Insurance Policies

The bill also reduces the amounts CIGA pays on claims due to the claimant's recovery under other insurance policies. Current law reduces any claim against CIGA by the amount recovered under the claimant's insurance policy. The bill instead reduces the claim by either the (1) full applicable limits or (2) amount recovered under the other insurance policy. The bill specifies that CIGA must receive a full credit for the stated limits or recovered amount unless the claimant demonstrates that he or she used reasonable efforts to exhaust all applicable coverage and limits under the other policy.

The bill requires any such credit to be deducted from the lesser of (1) the association's covered claim limit, (2) the amount of the claim's judgment or settlement, or (3) the full applicable limit stated in the insolvent insurer's policy.

It also prohibits CIGA's obligation from exceeding the bill's coverage limits (see § 4 above).

The bill specifies that no insured covered under an insolvent insurer's policy is liable for any amount of the reduction made by the association to any amount paid to a third-party claimant.

The bill specifies that nothing in it relieves the association of its duty to defend under the insolvent insurer's policy, except to the extent the claimant has a contractual right to a defense under an insurance policy

issued by another insurer and except as otherwise limited under the CIGA Act.

Under the bill, an insurance policy claim other than that under a life insurance policy includes (1) a claim against an HMO, hospital or medical service corporation, or disability insurance company and (2) any amount payable by or on behalf of a self-insurer.

§ 8 — ACCESS TO RECORDS RELATED TO CIGA-COVERED CLAIMS

Current law requires an insolvent insurer's receiver to give the CIGA board access to and copies of the insolvent insurer's records related to covered claims. The bill requires the board to pay for the copies.

§ 9 — CLHIGA COVERAGE, LIMITATIONS, AND EXCLUSIONS

The bill excludes CLHIGA coverage for a policy or contract providing any hospital, medical, prescription drug, or other health care benefits under Medicare Part C of Part D. It also makes minor changes the statutes pertaining to CLHIGA coverage and limitations.

§ 10 — PUBLIC ACCESS TO CLHIGA MEETINGS AND RECORDS

The bill allows CLHIGA to open its meetings or records to the public upon a majority vote of its board of directors.

§ 13 — REINSURANCE ARRANGEMENTS

Reduced Timeframe to Assume Reinsurance Contracts

The bill reduces the timeframe within which CLHIGA may elect to assume the rights of an insolvent insurer under a reinsurance contract. It allows the association to do this within six months after the date of the insolvency, rather than within one year as allowed under current law. It requires the election to be exercised by notice to the receiver and the reinsurer, eliminating the current requirement for notice to the rehabilitator or liquidator.

The bill removes the provision prohibiting CLHIGA from exercising the election if the insolvent insurer's receiver, rehabilitator, or

liquidator disaffirmed the insurance agreement.

It also makes several minor changes to update terminology to conform to the NAIC Life and Health Insurance Guarantee Association Model Act.

Provision of Records

The bill requires the insolvent insurer's receiver and reinsurer, at the association's request, to make available (1) copies of reinsurance contracts in force and all related files and records relevant to the determination of whether to assume these contracts and (2) notices of any defaults under the reinsurance contracts or any known event or condition that, with passage of time, could become a default under the reinsurance contracts. This information must be made available as soon as possible after the beginning of formal delinquency proceedings in order to facilitate the association's earliest practicable decision whether to assume any reinsurance contracts entered into by an insolvent insurer and to protect the financial position of the insolvent insurer's estate.

Notification of Reinsurance Costs

By law, if CLHIGA assumes a reinsurance contract, it is responsible for performing all obligations related to covered policies or annuities once the insurer becomes insolvent, including charging covered policies or annuities the reinsurance costs that exceed CLHIGA's obligations. The bill requires the association to provide the receiver with a notice and accounting of these charges.

Payments for Losses or Events

By law, CLHIGA is entitled to amounts the reinsurer pays under the contract for losses or events that happened after date the insurer became insolvent. Under the bill, CLHIGA must pay a beneficiary of a policy or annuity where an amount was paid, a portion of the amount that is the lesser of (a) the amount it received or (b) the amount received that exceeds the benefits paid by the association on account of the policy or annuity less any amount retained by the insurer

applicable to the loss or event.

Current law requires CLHIGA to pay a beneficiary of a policy or contract in which it paid only a portion of the amount due (a) the amount it received that exceeds the benefits paid the beneficiary under the policy or contract less (b) any amount retained by the impaired or insolvent insurer applicable to the loss or event.

Net Balance Due

By law, CLHIGA must calculate, within 30 days after it elects to assume a contract, along with each reinsurer whose contracts it assumed, the net balance due to or from CLHIGA under each reinsurance contract as of the date of its election. The bill requires the reinsurer to pay the receiver any amounts due for losses or events that happened before the date the order of liquidation was entered, subject to any set off unpaid premiums before that date. It also requires the reinsurer or CLHIGA to pay any remaining balance it owes the other within five days after completing the calculation.

The bill requires any dispute over the amount due to CLHIGA or the reinsurer to be resolved by arbitration pursuant to the terms of the affected reinsurance contract or, if the contract does not contain an arbitration clause, as provided by law.

Premium Payments

The bill specifies that if CLHIGA, or the receiver on CLHIGA's behalf, pays the premiums relating to partially or wholly covered policies or annuities within 60 days after its election for the periods before and after the election date, the reinsurer cannot terminate the reinsurance contracts for nonpayment of premiums or set off against amounts due CLHIGA for any unpaid amounts due under other contracts or from parties other than CLHIGA.

Rights and Obligations; Access to Records

The bill specifies that during the period from the order of liquidation's entry date until the election date, or if there is no election, until 6 months after the entry date, neither CLHIGA nor the reinsurer

have any rights or obligations under reinsurance contracts CLHIGA has the right to assume. It requires CLHIGA, the receiver, and the reinsurer, to the extent practicable, to provide each other data and records that each reasonably requests. Once CLHIGA elects to assume a reinsurance contract, the rights and obligations of CLHIGA and the reinsurer are governed by the bill's provisions.

It also specifies that if CLHIGA does not elect to assume a reinsurance contract by the election date, it has no rights or obligations regarding the contract.

Transferring Obligations to Another Insurer

Under the bill, when a receiver transfers policies, annuities, or covered obligations to another insurer, CLHIGA may transfer to that insurer any reinsurance contract it assumed on those policies or annuities under the following conditions:

1. the reinsurance contract must not cover any new policies or annuities in addition to those transferred unless the reinsurer and the other insurer otherwise agrees,
2. CLHIGA's obligation regarding losses or events arising on or after the effective date no longer applies on or after the date the reinsurance contract is transferred, and
3. the association provides written notice, return receipt requested, to the affected reinsurer at least 30 days before the transfer of the reinsurance contract takes effect.

It also specifies that nothing in the bill (1) limits or affects CLHIGA's right as a creditor of the insolvent insurer's estate or (2) applies to reinsurance or property or casualty risks.

§ 16 — CLHIGA PLAN OF OPERATION

The law requires CLHIGA's plan of operation to establish regular places and times for its board of directors meetings. The bill specifies that this includes telephone conference calls.

§ 17 — APPEALS OF CLHIGA ACTIONS

The bill allows a member insurer to appeal only a final action of CLHIGA or its board, rather than any action as allowed under current law. The law, unchanged by the bill, requires appeals to be made within 30 days of the action.

The bill also replaces a reference to “impaired insurer” with “impaired or insolvent insurer” regarding the ability of a liquidator, receiver, or conservator to notify interested persons of CLHIGA coverage.

§ 18 — RECEIVERSHIP DISBURSEMENTS

The bill entitles CLHIGA, as a creditor of an impaired or insolvent insurer, to receive a disbursement of available assets from the insurer’s marshaled assets as credits against the association’s contractual obligations. It allows CLHIGA to petition the receivership court for this disbursement if the liquidator does not do so within 120 days of the date the court determines the insurer insolvent.

The bill requires CLHIGA’s receivership claim to be paid in full with interest, at a rate determined by the liquidator, before any receivership disbursement is made.

The bill also replaces references to “impaired insurer” with “impaired or insolvent insurer” in the statutes regarding liability of unpaid CLHIGA assessments.

§ 18 — PROHIBITION AGAINST CERTAIN INSURANCE MARKETING AND SOLICITATION

The bill expands the prohibition against using the protections afforded policyholders through CLHIGA to solicit or procure insurance. It prohibits any person, including an insurer, agent, or affiliate, from making, publishing, disseminating, or placing before the public (or causing such action) any written or oral advertisement, announcement, or statement using CLHIGA’s existence to sell, solicit, or induce the purchase any CLHIGA-covered insurance.

It also removes the statutory provision designating a violation of this prohibition as an unfair trade practice under the Connecticut Unfair Insurance Practices Act.

§ 18 — CLHIGA SUMMARY DOCUMENT

The bill requires CLHIGA to prepare a summary document describing its purpose and limitations. The association must prepare and submit the document to the insurance commissioner by April 1, 2012, for approval. Once it is approved, the association must notify its member insurers that the document is available and of the requirements regarding its distribution (see below). The document must be revised as necessary to maintain its accuracy.

The bill prohibits a member insurer, within 60 days of the document's approval, from delivering a policy or contract unless it includes a copy of the summary document. The insurer must also provide the document to a policy or contract owner upon request. It specifies that the document is not a guarantee that the policy or contract, or its owner, is covered in the event the member insurer becomes impaired or insolvent. It also provides that if a member insurer does not provide the summary document, the policy or contract owner does not have any rights beyond those specified under the CLHIGA Act.

Disclaimer

The bill requires the summary document to include a clear and conspicuous disclaimer. The insurance commissioner must establish the form and content of the disclaimer, which must include:

1. the name and address of CLHIGA and the Insurance Department;
2. a prominent warning that CLHIGA may not cover the policy or contract and if it does, the coverage is subject to substantial limitations and exclusions and is conditioned upon the policy or contract owner remaining a Connecticut resident;

3. a statement of the types of coverage the association provides;
4. a statement that the insurer and its agents are prohibited by law from using CLHIGA's existence to sell, solicit, or induce the purchase of any insurance;
5. a statement that the policy or contract owners should not rely on CLHIGA coverage when selecting an insurer;
6. an explanation of the policy or contract owner's rights and the procedures for filing a complaint for violations of the CLHIGA Act; and
7. any other information the insurance commissioner prescribes, including information sources about insurers' financial condition, provided the information is not proprietary and can be disclosed under the Freedom of Information Act.

The bill requires a member insurer to keep evidence of its compliance with these requirements, as established by the insurance commissioner, for as long as the policy or contract remains in effect.

§§ 2, 4, 5, 9, 19, 20 — TECHNICAL CHANGES

The bill makes several technical and conforming changes to the statutes regarding CIGA and CLHIGA.

BACKGROUND

Insurance Guaranty Associations

By law, 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 ceilings fixed by state law.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 10 Nay 7 (03/10/2011)