



General Assembly

February Session, 2014

Raised Bill No. 5253

LCO No. 149



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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

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

1 Section 1. Subdivision (6) of section 38a-838 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective*
3 *October 1, 2014*):

4 (6) "Insolvent insurer" means an insurer (A) (i) licensed to transact
5 insurance in this state either at the time the policy was issued or when
6 the insured event occurred, and (ii) [determined to be insolvent]
7 against which a final order of liquidation with a finding of insolvency
8 has been entered by a court of competent jurisdiction in the insurer's
9 state of domicile; (B) [which] that is (i) the legal successor of an insurer
10 that was licensed to transact insurance in this state either at the time
11 the policy was issued or when the insured event occurred, by reason of
12 a merger, provided such merger is approved by an insurance regulator
13 having jurisdiction over such merger, and (ii) [determined to be
14 insolvent] against which a final order of liquidation with a finding of

15 insolvency has been entered by a court of competent jurisdiction in the
16 successor insurer's state of domicile; or (C) [which] that (i) succeeds to
17 the policy obligations of an insurer that was licensed to transact
18 insurance in this state either at the time the policy was issued or when
19 the insured event occurred, by reason of a division whereby policies
20 issued by such licensed insurer are transferred to an insurer, [and (ii) is
21 determined to be insolvent by a court of competent jurisdiction,]
22 provided such division is approved (I) in a jurisdiction that allows
23 such division, and (II) by an insurance regulator having jurisdiction
24 over such division, and (ii) against which a final order of liquidation
25 with a finding of insolvency has been entered by a court of competent
26 jurisdiction in the succeeding insurer's state of domicile. "Insolvent
27 insurer" shall not be construed to mean any insurer with respect to
28 which an order, decree, judgment or finding of insolvency, whether
29 permanent or temporary in nature, or order of rehabilitation or
30 conservation has been issued by a court of competent jurisdiction prior
31 to October 1, 1971;

32 Sec. 2. Subsection (a) of section 38a-841 of the general statutes is
33 repealed and the following is substituted in lieu thereof (*Effective*
34 *October 1, 2014*):

35 (a) Said association shall: (1) Be obligated to the extent of the
36 covered claims existing prior to the [determination of insolvency] entry
37 of the final order of liquidation with a finding of insolvency and
38 arising within [thirty] sixty days after the [determination of
39 insolvency] entry of such order, or before the policy expiration date if
40 less than [thirty] sixty days after the [determination] entry of such
41 order, or before the insured replaces the policy or causes its
42 cancellation, if [he] the insured does so [within thirty days of such
43 determination] not later than sixty days after the entry of such order,
44 provided such obligation shall be limited as follows: (A) With respect
45 to covered claims for unearned premiums, to one-half of the unearned
46 premium on any policy, subject to a maximum of two thousand dollars
47 per policy; (B) with respect to covered claims other than for unearned

48 premiums, such obligation shall include only that amount of each such
49 claim [which] that is in excess of one hundred dollars and is less than
50 (i) three hundred thousand dollars for claims arising under policies of
51 insurers determined to be insolvent prior to October 1, 2007, [and] (ii)
52 four hundred thousand dollars for claims arising under policies of
53 insurers determined to be insolvent on or after October 1, 2007, and
54 prior to October 1, 2014, and (iii) five hundred thousand dollars for
55 claims arising under policies of insurers against which a final order of
56 liquidation with a finding of insolvency has been entered by a court of
57 competent jurisdiction on or after October 1, 2014, except that said
58 association shall pay the full amount of any such claim arising out of a
59 workers' compensation policy, provided in no event shall said
60 association be obligated [(i)] (I) to any claimant in an amount in excess
61 of the obligation of the insolvent insurer under the policy form or
62 coverage from which the claim arises, or [(ii)] (II) for any claim filed
63 with the association after the expiration of two years from the date of
64 the declaration of insolvency unless such claim arose out of a workers'
65 compensation policy and was timely filed in accordance with section
66 31-294c; (2) be deemed the insurer to the extent of its obligations on the
67 covered claims and to such extent shall have all rights, duties, and
68 obligations of the insolvent insurer as if the insurer had not become
69 insolvent; (3) allocate claims paid and expenses incurred among the
70 three accounts, created by section 38a-839, separately, and assess
71 member insurers separately (A) in respect of each such account for
72 such amounts as shall be necessary to pay the obligations of said
73 association under subdivision (1) of this subsection subsequent to an
74 insolvency; (B) the expenses of handling covered claims subsequent to
75 an insolvency; (C) the cost of examinations under section 38a-846; and
76 (D) such other expenses as are authorized by sections 38a-836 to 38a-
77 853, inclusive. The assessments of each member insurer shall be in the
78 proportion that the net direct written premiums of such member
79 insurer for the calendar year preceding the assessment on the kinds of
80 insurance in such account bears to the net direct written premiums of
81 all member insurers for the calendar year preceding the assessment on

82 the kinds of insurance in such account. Each member insurer shall be
83 notified of its assessment not later than thirty days before it is due. No
84 member insurer may be assessed in any year on any account an
85 amount greater than two per cent of that member insurer's net direct
86 written premiums for the calendar year preceding the assessment on
87 the kinds of insurance in said account, provided if, at the time an
88 assessment is levied on the all other insurance account, as defined in
89 subdivision (3) of section 38a-839, the board of directors finds that at
90 least fifty per cent of the total net direct written premiums of a member
91 insurer and all its affiliates, for the year on which such assessment is
92 based, were from policies issued or delivered in Connecticut, on risks
93 located in this state, such member insurer shall be assessed only on
94 such member insurer's net direct written premium that is attributable
95 to the kind of insurance that gives rise to each covered claim. If the
96 maximum assessment, together with the other assets of said
97 association in any account, does not provide in any one year in any
98 account an amount sufficient to make all necessary payments from that
99 account, the funds available may be prorated and the unpaid portion
100 shall be paid as soon thereafter as funds become available. Said
101 association may defer, in whole or in part, the assessment of any
102 member insurer, if the assessment would cause the member insurer's
103 financial statement to reflect amounts of capital or surplus less than the
104 minimum amounts required for a certificate of authority by any
105 jurisdiction in which the member insurer is authorized to transact
106 insurance provided that during the period of deferment, no dividends
107 shall be paid to shareholders or policyholders. Deferred assessments
108 shall be paid when such payment will not reduce capital or surplus
109 below the minimum amounts required for a certificate of authority.
110 Such payments shall be refunded to those insurers receiving greater
111 assessments because of such deferment or, at the election of the
112 insurer, be credited against future assessments. Each member insurer
113 serving as a servicing facility may set off against any assessment,
114 authorized payments made on covered claims and expenses incurred
115 in the payment of such claims by such member insurer if they are

116 chargeable to the account in respect of which the assessment is made;
117 (4) investigate claims brought against said association and adjust,
118 compromise, settle, and pay covered claims to the extent of said
119 association's obligations, and deny all other claims. The association
120 shall pay claims in any order it deems reasonable including, but not
121 limited to, payment in the order of receipt or by classification. It may
122 review settlements, releases and judgments to which the insolvent
123 insurer or its insureds were parties to determine the extent to which
124 such settlements, releases and judgments may be properly contested;
125 (5) notify such persons as the commissioner may direct under
126 subdivision (1) of subsection (b) of section 38a-843, as amended by this
127 act; (6) handle claims through its employees or through one or more
128 insurers or other persons designated by said association as servicing
129 facilities, provided such designation of a servicing facility shall be
130 subject to the approval of the commissioner, and may be declined by a
131 member insurer; (7) reimburse each such servicing facility for
132 obligations of said association paid by such facility and for expenses
133 incurred by such facility while handling claims on behalf of said
134 association and shall pay such other expenses of said association as are
135 authorized by sections 38a-836 to 38a-853, inclusive.

136 Sec. 3. Subsections (a) and (b) of section 38a-843 of the general
137 statutes are repealed and the following is substituted in lieu thereof
138 (*Effective October 1, 2014*):

139 (a) The commissioner shall: (1) Notify said association of the
140 existence of an insolvent insurer, and notify the chairman of the
141 Workers' Compensation Commission and the State Treasurer of the
142 existence of an insolvent workers' compensation insurer, not later than
143 three days after [he] the commissioner receives notice [of the
144 determination] of any such insolvency; (2) upon request of the board of
145 directors, provide said association with a statement of the net direct
146 written premiums of each member insurer.

147 (b) The commissioner may: (1) Require that said association notify

148 those persons insured by the insolvent insurer, and any other
149 interested parties, of the [determination] entry of a final order of
150 liquidation with a finding of insolvency and of their rights under
151 sections 38a-836 to 38a-853, inclusive. Such notification shall be by mail
152 sent to their last known address, where available, provided if sufficient
153 information for such notification by mail is not available, notice by
154 publication in a newspaper of general circulation shall be sufficient to
155 satisfy the requirements of this subsection; (2) suspend or revoke, after
156 notice and hearing, the certificate of authority to transact insurance in
157 this state of any member insurer that fails to pay an assessment when
158 due or which fails to comply with said plan of operation. In lieu of
159 such suspension or revocation, the commissioner may levy a fine on
160 any member insurer [which] that fails to pay an assessment when due,
161 provided no such fine shall exceed five per cent of the unpaid
162 assessment per month, and provided no fine shall be less than five
163 hundred dollars per month; (3) revoke the designation of any servicing
164 facility if the commissioner finds claims are being handled
165 unsatisfactorily.

166 Sec. 4. Subsection (f) of section 38a-860 of the general statutes is
167 repealed and the following is substituted in lieu thereof (*Effective*
168 *October 1, 2014*):

169 (f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage
170 to the persons specified in subsections (a) to (d), inclusive, of this
171 section for direct, nongroup life, health or annuity policies or contracts
172 and supplemental contracts to such policies or contracts, for certificates
173 under direct group policies and contracts, and for unallocated annuity
174 contracts issued by member insurers, except as limited by said
175 sections. Annuity contracts and certificates under group annuity
176 contracts include, but are not limited to, guaranteed investment
177 contracts, deposit administration contracts, unallocated funding
178 agreements, allocated funding agreements, structured settlement
179 annuities, annuities issued to or in connection with government
180 lotteries and any immediate or deferred annuity contracts.

181 (2) [Said sections] Sections 38a-858 to 38a-875, inclusive, shall not
182 provide coverage for: (A) Any portion of a policy or contract not
183 guaranteed by the insurer, or under which the risk is borne by the
184 policy or contract holder; (B) any policy or contract of reinsurance,
185 unless assumption certificates have been issued; (C) any portion of a
186 policy or contract to the extent that the rate of interest on which it is
187 based or the interest rate, crediting rate or similar factor determined by
188 use of an index or other external reference stated in the policy or
189 contract employed in calculating returns or changes in value (i)
190 averaged over the period of four years prior to the date on which the
191 member insurer becomes an impaired or insolvent insurer under
192 sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest
193 determined by subtracting two percentage points from Moody's
194 corporate bond yield average averaged for that same four-year period
195 or for such lesser period if the policy or contract was issued less than
196 four years before the member insurer becomes an impaired or
197 insolvent insurer under sections 38a-858 to 38a-875, inclusive,
198 whichever is earlier, [;] and (ii) on and after the date on which the
199 member insurer becomes an impaired or insolvent insurer under
200 sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the
201 rate of interest determined by subtracting three percentage points from
202 Moody's corporate bond yield average as most recently available; (D) a
203 portion of a policy or contract issued to any plan or program of an
204 employer, association or similar entity to provide life, health or
205 annuity benefits to its employees or members to the extent that such
206 plan or program is self-funded or uninsured, including, but not limited
207 to, benefits payable by an employer, association or similar entity under
208 (i) a multiple employer welfare arrangement as defined in Section 514
209 of the federal Employee Retirement Income Security Act of 1974, as
210 amended from time to time, [;] (ii) a minimum premium group
211 insurance plan, [;] or (iii) an administrative services only contract; (E)
212 any stop-loss or excess loss insurance policy or contract providing for
213 the indemnification of or payment to a policy owner, a contract owner,
214 a plan or another person obligated to pay life, health or annuity

215 benefits; (F) any portion of a policy or contract to the extent that it
216 provides dividends, experience rating credits, voting rights or
217 provides that any fees or allowances be paid to any person, including,
218 but not limited to, the policy or contract holder, in connection with the
219 service to or administration of such policy or contract; (G) any policy
220 or contract issued in this state by a member insurer at a time when it
221 was not licensed or did not have a certificate of authority to issue such
222 policy or contract in this state; (H) any unallocated annuity contract
223 issued to an employee benefit plan protected under the federal Pension
224 Benefit Guaranty Corporation, regardless of whether the federal
225 Pension Benefit Guaranty Corporation has yet become liable to make
226 any payments with respect to the benefit plan; (I) any portion of an
227 unallocated annuity contract that is not issued to, or in connection with
228 a specific employee, union or association of natural persons benefit
229 plan or a government lottery; (J) any subscriber contract issued by a
230 health care center; (K) a contractual agreement that establishes the
231 insurer's obligation by reference to a portfolio of assets that is not
232 owned or possessed by the insurance company; (L) an obligation that
233 does not arise under the express written terms of the policy or contract
234 issued by the insurer to the contract owner or policy owner, including,
235 but not limited to, [; (i) A] (i) a claim based on marketing materials, [;]
236 (ii) a claim based on side letters, riders or other documents that were
237 issued by the insurer without meeting applicable policy form filing or
238 approval requirements, [;] (iii) a misrepresentation of or regarding
239 policy benefits, [;] (iv) an extra-contractual claim, [;] or (v) a claim for
240 penalties or consequential or incidental damages; (M) a contractual
241 agreement that establishes the member insurer's obligations to provide
242 a book value accounting guaranty for defined contribution benefit plan
243 participants by reference to a portfolio of assets that is owned by the
244 benefit plan or its trustee, which in each case is not an affiliate of the
245 member insurer; [and] (N) a portion of a policy or contract to the
246 extent it provides for interest or other changes in value to be
247 determined by the use of an index or other external reference stated in
248 the policy or contract, but [which] that have not been credited to the

249 policy or contract, or as to which the policy or contract owner's rights
 250 are subject to forfeiture, as of the date the member insurer becomes an
 251 impaired or insolvent insurer under sections 38a-858 to 38a-875,
 252 inclusive, whichever is earlier. If a policy's or contract's interest or
 253 changes in value are credited less frequently than annually, then for
 254 purposes of determining the values that have been credited and are
 255 not subject to forfeiture under this subparagraph, the interest or
 256 change in value determined by using the procedures defined in the
 257 policy or contract shall be credited as if the contractual date of
 258 crediting interest or changing values was the date of impairment or
 259 insolvency, whichever is earlier, and shall not be subject to forfeiture;
 260 and (O) any policy or contract providing hospital, medical,
 261 prescription drugs or other health care benefits pursuant to Part C, 42
 262 USC 1395w21 et seq., or Part D, 42 USC 1395w101 et seq., as both may
 263 be amended from time to time, or any regulations adopted thereunder.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2014</i>	38a-838(6)
Sec. 2	<i>October 1, 2014</i>	38a-841(a)
Sec. 3	<i>October 1, 2014</i>	38a-843(a) and (b)
Sec. 4	<i>October 1, 2014</i>	38a-860(f)

Statement of Purpose:

To require a final order of liquidation instead of a determination of insolvency to trigger liquidation proceedings under CIGA, change the time period of coverage of covered claims under CIGA from thirty days to sixty days, increase the maximum coverage amount for claims under CIGA, and exclude Medicare Part C and Part D policies and contracts from coverage under CLHIGA.

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