



House of Representatives

File No. 676

General Assembly

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House Bill No. 6387
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 10, 2021

***AN ACT CONCERNING INSURANCE DISCRIMINATION AGAINST
LIVING ORGAN DONORS AND ESTABLISHING A CHRONIC KIDNEY
DISEASE ADVISORY COMMITTEE.***

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

1 Section 1. Section 38a-1 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2022*):

3 Terms used in this title and section 2 of this act, unless it appears from
4 the context to the contrary, shall have a scope and meaning as set forth
5 in this section.

6 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly
7 through one or more intermediaries, controls, is controlled by or is
8 under common control with another person.

9 (2) "Alien insurer" means any insurer that has been chartered by or
10 organized or constituted within or under the laws of any jurisdiction or
11 country without the United States.

12 (3) "Annuities" means all agreements to make periodical payments
13 where the making or continuance of all or some of the series of the
14 payments, or the amount of the payment, is dependent upon the
15 continuance of human life or is for a specified term of years. This
16 definition does not apply to payments made under a policy of life
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

19 (5) "Control", "controlled by" or "under common control with" means
20 the possession, direct or indirect, of the power to direct or cause the
21 direction of the management and policies of a person, whether through
22 the ownership of voting securities, by contract other than a commercial
23 contract for goods or nonmanagement services, or otherwise, unless the
24 power is the result of an official position with the person.

25 (6) "Domestic insurer" means any insurer that has been chartered by,
26 incorporated, organized or constituted within or under the laws of this
27 state.

28 (7) "Domestic surplus lines insurer" means any domestic insurer that
29 has been authorized by the commissioner to write surplus lines
30 insurance.

31 (8) "Foreign country" means any jurisdiction not in any state, district
32 or territory of the United States.

33 (9) "Foreign insurer" means any insurer that has been chartered by or
34 organized or constituted within or under the laws of another state or a
35 territory of the United States.

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
37 unable to pay its obligations when they are due, or when its admitted
38 assets do not exceed its liabilities plus the greater of: (A) Capital and
39 surplus required by law for its organization and continued operation;
40 or (B) the total par or stated value of its authorized and issued capital
41 stock. For purposes of this subdivision "liabilities" shall include but not

42 be limited to reserves required by statute or by regulations adopted by
43 the commissioner in accordance with the provisions of chapter 54 or
44 specific requirements imposed by the commissioner upon a subject
45 company at the time of admission or subsequent thereto.

46 (11) "Insurance" means any agreement to pay a sum of money,
47 provide services or any other thing of value on the happening of a
48 particular event or contingency or to provide indemnity for loss in
49 respect to a specified subject by specified perils in return for a
50 consideration. In any contract of insurance, an insured shall have an
51 interest which is subject to a risk of loss through destruction or
52 impairment of that interest, which risk is assumed by the insurer and
53 such assumption shall be part of a general scheme to distribute losses
54 among a large group of persons bearing similar risks in return for a
55 ratable contribution or other consideration.

56 (12) "Insurer" or "insurance company" includes any person or
57 combination of persons doing any kind or form of insurance business
58 other than a fraternal benefit society, and shall include a receiver of any
59 insurer when the context reasonably permits.

60 (13) "Insured" means a person to whom or for whose benefit an
61 insurer makes a promise in an insurance policy. The term includes
62 policyholders, subscribers, members and beneficiaries. This definition
63 applies only to the provisions of this title and does not define the
64 meaning of this word as used in insurance policies or certificates.

65 (14) "Life insurance" means insurance on human lives and insurances
66 pertaining to or connected with human life. The business of life
67 insurance includes granting endowment benefits, granting additional
68 benefits in the event of death by accident or accidental means, granting
69 additional benefits in the event of the total and permanent disability of
70 the insured, and providing optional methods of settlement of proceeds.
71 Life insurance includes burial contracts to the extent provided by
72 section 38a-464.

73 (15) "Mutual insurer" means any insurer without capital stock, the

74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a
76 limited liability company, an association, a joint stock company, a
77 business trust, an unincorporated organization or other legal entity.

78 (17) "Policy" means any document, including attached endorsements
79 and riders, purporting to be an enforceable contract, which
80 memorializes in writing some or all of the terms of an insurance
81 contract.

82 (18) "State" means any state, district, or territory of the United States.

83 (19) "Subsidiary" of a specified person means an affiliate controlled
84 by the person directly, or indirectly through one or more intermediaries.

85 (20) "Unauthorized insurer" or "nonadmitted insurer" means an
86 insurer that has not been granted a certificate of authority by the
87 commissioner to transact the business of insurance in this state or an
88 insurer transacting business not authorized by a valid certificate.

89 (21) "United States" means the United States of America, its territories
90 and possessions, the Commonwealth of Puerto Rico and the District of
91 Columbia.

92 Sec. 2. (NEW) (*Effective January 1, 2022*) (a) Notwithstanding any
93 provision of the general statutes, no insurer delivering, issuing for
94 delivery or amending a life insurance policy, long-term care insurance
95 policy or a policy providing disability income protection coverage in
96 this state on or after January 1, 2022, shall, for any such policy issued on
97 or after said date:

98 (1) Decline to provide coverage, or limit the coverage provided, for
99 an individual under such policy solely because the individual is a living
100 organ donor;

101 (2) Preclude an individual from donating all or part of an organ as a
102 condition to maintaining coverage under such policy; or

103 (3) Otherwise engage in discrimination in offering, issuing for
104 delivery, amending or cancelling, or in setting the amount, price or
105 conditions of, coverage for an individual under such policy solely
106 because the individual is a living organ donor.

107 (b) Any violation of this section shall be deemed an unfair method of
108 competition and unfair and deceptive act or practice in the business of
109 insurance under section 38a-816 of the general statutes, as amended by
110 this act.

111 Sec. 3. Section 38a-816 of the general statutes is repealed and the
112 following is substituted in lieu thereof (*Effective January 1, 2022*):

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

115 (1) Misrepresentations and false advertising of insurance policies.
116 Making, issuing or circulating, or causing to be made, issued or
117 circulated, any estimate, illustration, circular or statement, sales
118 presentation, omission or comparison which: (A) Misrepresents the
119 benefits, advantages, conditions or terms of any insurance policy; (B)
120 misrepresents the dividends or share of the surplus to be received, on
121 any insurance policy; (C) makes any false or misleading statements as
122 to the dividends or share of surplus previously paid on any insurance
123 policy; (D) is misleading or is a misrepresentation as to the financial
124 condition of any person, or as to the legal reserve system upon which
125 any life insurer operates; (E) uses any name or title of any insurance
126 policy or class of insurance policies misrepresenting the true nature
127 thereof; (F) is a misrepresentation, including, but not limited to, an
128 intentional misquote of a premium rate, for the purpose of inducing or
129 tending to induce to the purchase, lapse, forfeiture, exchange,
130 conversion or surrender of any insurance policy; (G) is a
131 misrepresentation for the purpose of effecting a pledge or assignment of
132 or effecting a loan against any insurance policy; or (H) misrepresents
133 any insurance policy as being shares of stock.

134 (2) False information and advertising generally. Making, publishing,

135 disseminating, circulating or placing before the public, or causing,
136 directly or indirectly, to be made, published, disseminated, circulated or
137 placed before the public, in a newspaper, magazine or other publication,
138 or in the form of a notice, circular, pamphlet, letter or poster, or over any
139 radio or television station, or in any other way, an advertisement,
140 announcement or statement containing any assertion, representation or
141 statement with respect to the business of insurance or with respect to
142 any person in the conduct of his insurance business, which is untrue,
143 deceptive or misleading.

144 (3) Defamation. Making, publishing, disseminating or circulating,
145 directly or indirectly, or aiding, abetting or encouraging the making,
146 publishing, disseminating or circulating of, any oral or written
147 statement or any pamphlet, circular, article or literature which is false
148 or maliciously critical of or derogatory to the financial condition of an
149 insurer, and which is calculated to injure any person engaged in the
150 business of insurance.

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

155 (5) False financial statements. Filing with any supervisory or other
156 public official, or making, publishing, disseminating, circulating or
157 delivering to any person, or placing before the public, or causing,
158 directly or indirectly, to be made, published, disseminated, circulated or
159 delivered to any person, or placed before the public, any false statement
160 of financial condition of an insurer with intent to deceive; or making any
161 false entry in any book, report or statement of any insurer with intent to
162 deceive any agent or examiner lawfully appointed to examine into its
163 condition or into any of its affairs, or any public official to whom such
164 insurer is required by law to report, or who has authority by law to
165 examine into its condition or into any of its affairs, or, with like intent,
166 wilfully omitting to make a true entry of any material fact pertaining to
167 the business of such insurer in any book, report or statement of such

168 insurer.

169 (6) Unfair claim settlement practices. Committing or performing with
170 such frequency as to indicate a general business practice any of the
171 following: (A) Misrepresenting pertinent facts or insurance policy
172 provisions relating to coverages at issue; (B) failing to acknowledge and
173 act with reasonable promptness upon communications with respect to
174 claims arising under insurance policies; (C) failing to adopt and
175 implement reasonable standards for the prompt investigation of claims
176 arising under insurance policies; (D) refusing to pay claims without
177 conducting a reasonable investigation based upon all available
178 information; (E) failing to affirm or deny coverage of claims within a
179 reasonable time after proof of loss statements have been completed; (F)
180 not attempting in good faith to effectuate prompt, fair and equitable
181 settlements of claims in which liability has become reasonably clear; (G)
182 compelling insureds to institute litigation to recover amounts due under
183 an insurance policy by offering substantially less than the amounts
184 ultimately recovered in actions brought by such insureds; (H)
185 attempting to settle a claim for less than the amount to which a
186 reasonable man would have believed he was entitled by reference to
187 written or printed advertising material accompanying or made part of
188 an application; (I) attempting to settle claims on the basis of an
189 application which was altered without notice to, or knowledge or
190 consent of the insured; (J) making claims payments to insureds or
191 beneficiaries not accompanied by statements setting forth the coverage
192 under which the payments are being made; (K) making known to
193 insureds or claimants a policy of appealing from arbitration awards in
194 favor of insureds or claimants for the purpose of compelling them to
195 accept settlements or compromises less than the amount awarded in
196 arbitration; (L) delaying the investigation or payment of claims by
197 requiring an insured, claimant, or the physician of either to submit a
198 preliminary claim report and then requiring the subsequent submission
199 of formal proof of loss forms, both of which submissions contain
200 substantially the same information; (M) failing to promptly settle claims,
201 where liability has become reasonably clear, under one portion of the

202 insurance policy coverage in order to influence settlements under other
203 portions of the insurance policy coverage; (N) failing to promptly
204 provide a reasonable explanation of the basis in the insurance policy in
205 relation to the facts or applicable law for denial of a claim or for the offer
206 of a compromise settlement; (O) using as a basis for cash settlement with
207 a first party automobile insurance claimant an amount which is less than
208 the amount which the insurer would pay if repairs were made unless
209 such amount is agreed to by the insured or provided for by the
210 insurance policy.

211 (7) Failure to maintain complaint handling procedures. Failure of any
212 person to maintain complete record of all the complaints which it has
213 received since the date of its last examination. This record shall indicate
214 the total number of complaints, their classification by line of insurance,
215 the nature of each complaint, the disposition of these complaints, and
216 the time it took to process each complaint. For purposes of this
217 subsection "complaint" means any written communication primarily
218 expressing a grievance.

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

223 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-
224 488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following
225 practices shall be considered discrimination within the meaning of
226 section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-
227 825: (A) Paying bonuses to policyholders or otherwise abating their
228 premiums in whole or in part out of surplus accumulated from
229 nonparticipating insurance, provided any such bonuses or abatement of
230 premiums shall be fair and equitable to policyholders and for the best
231 interests of the company and its policyholders; (B) in the case of policies
232 issued on the industrial debit plan, making allowance to policyholders
233 who have continuously for a specified period made premium payments
234 directly to an office of the insurer in an amount which fairly represents

235 the saving in collection expense; (C) readjustment of the rate of premium
236 for a group insurance policy based on loss or expense experience, or
237 both, at the end of the first or any subsequent policy year, which may be
238 made retroactive for such policy year.

239 (10) Notwithstanding any provision of any policy of insurance,
240 certificate or service contract, whenever such insurance policy or
241 certificate or service contract provides for reimbursement for any
242 services which may be legally performed by any practitioner of the
243 healing arts licensed to practice in this state, reimbursement under such
244 insurance policy, certificate or service contract shall not be denied
245 because of race, color or creed nor shall any insurer make or permit any
246 unfair discrimination against particular individuals or persons so
247 licensed.

248 (11) Favored agent or insurer: Coercion of debtors. (A) No person
249 may (i) require, as a condition precedent to the lending of money or
250 extension of credit, or any renewal thereof, that the person to whom
251 such money or credit is extended or whose obligation the creditor is to
252 acquire or finance, negotiate any policy or contract of insurance through
253 a particular insurer or group of insurers or producer or group of
254 producers; (ii) unreasonably disapprove the insurance policy provided
255 by a borrower for the protection of the property securing the credit or
256 lien; (iii) require directly or indirectly that any borrower, mortgagor,
257 purchaser, insurer or producer pay a separate charge, in connection
258 with the handling of any insurance policy required as security for a loan
259 on real estate or pay a separate charge to substitute the insurance policy
260 of one insurer for that of another; or (iv) use or disclose information
261 resulting from a requirement that a borrower, mortgagor or purchaser
262 furnish insurance of any kind on real property being conveyed or used
263 as collateral security to a loan, when such information is to the
264 advantage of the mortgagee, vendor or lender, or is to the detriment of
265 the borrower, mortgagor, purchaser, insurer or the producer complying
266 with such a requirement.

267 (B) (i) Subparagraph (A)(iii) of this subdivision shall not include the

268 interest which may be charged on premium loans or premium
269 advancements in accordance with the security instrument. (ii) For
270 purposes of subparagraph (A)(ii) of this subdivision, such disapproval
271 shall be deemed unreasonable if it is not based solely on reasonable
272 standards uniformly applied, relating to the extent of coverage required
273 and the financial soundness and the services of an insurer. Such
274 standards shall not discriminate against any particular type of insurer,
275 nor shall such standards call for the disapproval of an insurance policy
276 because such policy contains coverage in addition to that required. (iii)
277 The commissioner may investigate the affairs of any person to whom
278 this subdivision applies to determine whether such person has violated
279 this subdivision. If a violation of this subdivision is found, the person in
280 violation shall be subject to the same procedures and penalties as are
281 applicable to other provisions of section 38a-815, subsections (b) and (e)
282 of section 38a-817 and this section. (iv) For purposes of this section,
283 "person" includes any individual, corporation, limited liability
284 company, association, partnership or other legal entity.

285 (12) Refusing to insure, refusing to continue to insure or limiting the
286 amount, extent or kind of coverage available to an individual or
287 charging an individual a different rate for the same coverage because of
288 physical disability, mental or nervous condition as set forth in section
289 38a-488a or intellectual disability, except where the refusal, limitation or
290 rate differential is based on sound actuarial principles or is related to
291 actual or reasonably anticipated experience.

292 (13) Refusing to insure, refusing to continue to insure or limiting the
293 amount, extent or kind of coverage available to an individual or
294 charging an individual a different rate for the same coverage solely
295 because of blindness or partial blindness. For purposes of this
296 subdivision, "refusal to insure" includes the denial by an insurer of
297 disability insurance coverage on the grounds that the policy defines
298 "disability" as being presumed in the event that the insured is blind or
299 partially blind, except that an insurer may exclude from coverage any
300 disability, consisting solely of blindness or partial blindness, when such
301 condition existed at the time the policy was issued. Any individual who

302 is blind or partially blind shall be subject to the same standards of sound
303 actuarial principles or actual or reasonably anticipated experience as are
304 sighted persons with respect to all other conditions, including the
305 underlying cause of the blindness or partial blindness.

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

310 (15) (A) Failure by an insurer, or any other entity responsible for
311 providing payment to a health care provider pursuant to an insurance
312 policy, to pay accident and health claims, including, but not limited to,
313 claims for payment or reimbursement to health care providers, within
314 the time periods set forth in subparagraph (B) of this subdivision, unless
315 the Insurance Commissioner determines that a legitimate dispute exists
316 as to coverage, liability or damages or that the claimant has fraudulently
317 caused or contributed to the loss. Any insurer, or any other entity
318 responsible for providing payment to a health care provider pursuant
319 to an insurance policy, who fails to pay such a claim or request within
320 the time periods set forth in subparagraph (B) of this subdivision shall
321 pay the claimant or health care provider the amount of such claim plus
322 interest at the rate of fifteen per cent per annum, in addition to any other
323 penalties which may be imposed pursuant to sections 38a-11, 38a-25,
324 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64,
325 inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129
326 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to
327 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
328 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
329 inclusive. Whenever the interest due a claimant or health care provider
330 pursuant to this section is less than one dollar, the insurer shall deposit
331 such amount in a separate interest-bearing account in which all such
332 amounts shall be deposited. At the end of each calendar year each such
333 insurer shall donate such amount to The University of Connecticut
334 Health Center.

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

338 (i) For claims filed in paper format, sixty days after receipt by the
339 insurer of the claimant's proof of loss form or the health care provider's
340 request for payment filed in accordance with the insurer's practices or
341 procedures, except that when there is a deficiency in the information
342 needed for processing a claim, as determined in accordance with section
343 38a-477, the insurer shall (I) send written notice to the claimant or health
344 care provider, as the case may be, of all alleged deficiencies in
345 information needed for processing a claim not later than thirty days
346 after the insurer receives a claim for payment or reimbursement under
347 the contract, and (II) pay claims for payment or reimbursement under
348 the contract not later than thirty days after the insurer receives the
349 information requested; and

350 (ii) For claims filed in electronic format, twenty days after receipt by
351 the insurer of the claimant's proof of loss form or the health care
352 provider's request for payment filed in accordance with the insurer's
353 practices or procedures, except that when there is a deficiency in the
354 information needed for processing a claim, as determined in accordance
355 with section 38a-477, the insurer shall (I) notify the claimant or health
356 care provider, as the case may be, of all alleged deficiencies in
357 information needed for processing a claim not later than ten days after
358 the insurer receives a claim for payment or reimbursement under the
359 contract, and (II) pay claims for payment or reimbursement under the
360 contract not later than ten days after the insurer receives the information
361 requested.

362 (C) As used in this subdivision, "health care provider" means a person
363 licensed to provide health care services under chapter 368d, chapter
364 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c,
365 inclusive, or chapter 400j.

366 (16) Failure to pay, as part of any claim for a damaged motor vehicle

367 under any automobile insurance policy where the vehicle has been
368 declared to be a constructive total loss, an amount equal to the sum of
369 (A) the settlement amount on such vehicle plus, whenever the insurer
370 takes title to such vehicle, (B) an amount determined by multiplying
371 such settlement amount by a percentage equivalent to the current sales
372 tax rate established in section 12-408. For purposes of this subdivision,
373 "constructive total loss" means the cost to repair or salvage damaged
374 property, or the cost to both repair and salvage such property, equals or
375 exceeds the total value of the property at the time of the loss.

376 (17) Any violation of section 42-260, by an extended warranty
377 provider subject to the provisions of said section, including, but not
378 limited to: (A) Failure to include all statements required in subsections
379 (c) and (f) of section 42-260 in an issued extended warranty; (B) offering
380 an extended warranty without being (i) insured under an adequate
381 extended warranty reimbursement insurance policy or (ii) able to
382 demonstrate that reserves for claims contained in the provider's
383 financial statements are not in excess of one-half the provider's audited
384 net worth; (C) failure to submit a copy of an issued extended warranty
385 form or a copy of such provider's extended warranty reimbursement
386 policy form to the Insurance Commissioner.

387 (18) With respect to an insurance company, hospital service
388 corporation, health care center or fraternal benefit society providing
389 individual or group health insurance coverage of the types specified in
390 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469,
391 refusing to insure, refusing to continue to insure or limiting the amount,
392 extent or kind of coverage available to an individual or charging an
393 individual a different rate for the same coverage because such
394 individual has been a victim of family violence.

395 (19) With respect to an insurance company, hospital service
396 corporation, health care center or fraternal benefit society providing
397 individual or group health insurance coverage of the types specified in
398 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469,
399 refusing to insure, refusing to continue to insure or limiting the amount,

400 extent or kind of coverage available to an individual or charging an
401 individual a different rate for the same coverage because of genetic
402 information. Genetic information indicating a predisposition to a
403 disease or condition shall not be deemed a preexisting condition in the
404 absence of a diagnosis of such disease or condition that is based on other
405 medical information. An insurance company, hospital service
406 corporation, health care center or fraternal benefit society providing
407 individual health coverage of the types specified in subdivisions (1), (2),
408 (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be
409 prohibited from refusing to insure or applying a preexisting condition
410 limitation, to the extent permitted by law, to an individual who has been
411 diagnosed with a disease or condition based on medical information
412 other than genetic information and has exhibited symptoms of such
413 disease or condition. For the purposes of this subsection, "genetic
414 information" means the information about genes, gene products or
415 inherited characteristics that may derive from an individual or family
416 member.

417 (20) Any violation of sections 38a-465 to 38a-465q, inclusive.

418 (21) With respect to a managed care organization, as defined in
419 section 38a-478, failing to establish a confidentiality procedure for
420 medical record information, as required by section 38a-999.

421 (22) Any violation of sections 38a-591d to 38a-591f, inclusive.

422 (23) Any violation of section 38a-472j.

423 (24) Any violation of section 2 of this act.

424 Sec. 4. (NEW) (*Effective from passage*) (a) There is established a chronic
425 kidney disease advisory committee. The advisory committee shall:

426 (1) Work directly with policymakers, public health organizations and
427 educational institutions to:

428 (A) Increase awareness of chronic kidney disease in this state; and

- 429 (B) Develop health education programs that:
- 430 (i) Are intended to reduce the burden of kidney disease throughout
431 this state;
- 432 (ii) Include an ongoing health and wellness campaign that is based
433 on relevant research;
- 434 (iii) Promote preventive screenings; and
- 435 (iv) Are promoted through social media and public relations
436 campaigns;
- 437 (2) Examine chronic kidney disease, kidney transplantation,
438 including, but not limited to, kidney transplantation as a preferred
439 treatment for chronic kidney disease, living and deceased kidney
440 donation and racial disparities in the rates of individuals afflicted with
441 chronic kidney disease;
- 442 (3) Examine methods to reduce the occurrence of chronic kidney
443 disease by controlling the most common risk factors, diabetes and
444 hypertension, through early detection and preventive efforts at the
445 community level and disease management efforts in the primary care
446 setting;
- 447 (4) Identify the barriers to the adoption of best practices and the
448 policies available to address such barriers;
- 449 (5) Develop an equitable, sustainable, cost-effective plan to raise
450 awareness about the importance of early detection, screening, diagnosis
451 and treatment of chronic kidney disease and prevention; and
- 452 (6) Examine the potential for an opt-out organ or kidney donor
453 registry.
- 454 (b) The advisory committee shall consist of the following members:
- 455 (1) The chairpersons and ranking members of the joint standing

456 committee of the General Assembly having cognizance of matters
457 relating to public health, or their designees;

458 (2) One appointed by the Senate chairperson of the joint standing
459 committee of the General Assembly having cognizance of matters
460 relating to public health;

461 (3) One appointed by the House chairperson of the joint standing
462 committee of the General Assembly having cognizance of matters
463 relating to public health;

464 (4) One appointed by the Senate ranking member of the joint standing
465 committee of the General Assembly having cognizance of matters
466 relating to public health;

467 (5) One appointed by the House ranking member of the joint standing
468 committee of the General Assembly having cognizance of matters
469 relating to public health;

470 (6) One appointed by the speaker of the House of Representatives,
471 who shall represent the renal provider community;

472 (7) One appointed by the president pro tempore of the Senate, who
473 shall represent a medical center with a kidney-related program;

474 (8) One appointed by the majority leader of the House of
475 Representatives;

476 (9) One appointed by the majority leader of the Senate;

477 (10) One appointed by the minority leader of the House of
478 Representatives;

479 (11) One appointed by the minority leader of the Senate;

480 (12) One appointed by the Governor;

481 (13) The Commissioner of Public Health, or the commissioner's
482 designee;

483 (14) One appointed by the chief executive officer of the National
484 Kidney Foundation;

485 (15) One appointed by the chief executive officer of the American
486 Kidney Fund; and

487 (16) At least three additional members appointed by the chairpersons
488 of the joint standing committee of the General Assembly having
489 cognizance of matters relating to public health, one of whom shall
490 represent the kidney physician community, one of whom shall
491 represent a nonprofit organ procurement organization, one of whom
492 shall represent the kidney patient community in this state and such
493 other members that such chairpersons, in their discretion, agree are
494 necessary to represent public health clinics, community health centers,
495 minority health organizations and health insurers.

496 (c) Any member of the advisory committee appointed under
497 subdivision (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11) or (16) of
498 subsection (b) of this section may be a member of the General Assembly.

499 (d) All initial appointments to the advisory committee shall be made
500 not later than thirty days after the effective date of this section. Any
501 vacancy shall be filled by the appointing authority.

502 (e) The speaker of the House of Representatives and the president pro
503 tempore of the Senate shall select the chairpersons of the advisory
504 committee from among the members of the advisory committee. Such
505 chairpersons shall schedule the first meeting of the advisory committee,
506 which shall be held not later than sixty days after the effective date of
507 this section. Meetings of the advisory committee may, at the discretion
508 of the chairpersons of the advisory committee, be conducted on a virtual
509 platform.

510 (f) The administrative staff of the advisory committee shall be
511 selected by the Office of Legislative Management in consultation with
512 the chairpersons of the advisory committee.

513 (g) Not later than January 1, 2022, and annually thereafter, the
514 advisory committee shall submit a report on its findings and
515 recommendations to the joint standing committee of the General
516 Assembly having cognizance of matters relating to public health in
517 accordance with the provisions of section 11-4a of the general statutes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2022</i>	38a-1
Sec. 2	<i>January 1, 2022</i>	New section
Sec. 3	<i>January 1, 2022</i>	38a-816
Sec.4	<i>from passage</i>	New section

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

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 \$	FY 23 \$
Resources of the General Fund	GF - Revenue Gain	Minimal	Minimal

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in a potential minimal revenue gain to the General Fund to the extent additional fines or penalties are assessed for violations of the Connecticut Unfair Insurance Practices Act (CUIPA). The bill prohibits certain insurers from discriminating against living organ donors and makes such actions a violation of CUIPA. CUIPA fines can range from \$5,000 per violation up to a maximum of \$250,000 in aggregate penalties per insurer in any six-month period.

There is no anticipated cost to the Insurance Department, as the agency has the necessary staff and expertise for enforcement.

House "A" establishes a nineteen-member chronic kidney disease advisory committee. The committee shall examine methods to reduce the occurrence of chronic kidney disease by controlling the most common risk factors, diabetes and hypertension, through early detection and preventive efforts at the community level and disease management efforts in the primary care setting.

The committee shall develop an equitable, sustainable, cost-effective plan to raise awareness about the importance of early detection,

screening, diagnosis and treatment of chronic kidney disease and prevention.

Not later than January 1, 2022, and annually thereafter, the advisory committee shall submit a report on its findings and recommendations to the Public Health committee.

House "A" has no fiscal impact as PA 17-236 prohibits transportation allowances for advisory committee members.

The Out Years

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

OLR Bill Analysis**HB 6387 (as amended by House "A")******AN ACT CONCERNING INSURANCE DISCRIMINATION AGAINST LIVING ORGAN DONORS.*****SUMMARY**

This bill prohibits an insurer issuing, delivering, or amending a life, long-term care, or disability-income protection insurance policy from discriminating against living organ donation by:

1. declining or limiting coverage solely because the insured is a living organ donor,
2. prohibiting the insured from donating an organ as a condition of maintaining coverage, or
3. otherwise discriminating in offering, delivering, issuing, amending, or cancelling a policy by setting prices, conditions, or coverage of the policy solely because the insured is a living organ donor.

The bill makes a violation of its provisions a Connecticut Unfair Insurance Practices Act (CUIPA) violation (see BACKGROUND).

The bill also establishes a chronic kidney disease advisory committee to, among other things, work with policymakers, public health organizations and educational institutions to increase awareness of chronic kidney disease and develop related educational programs. Beginning by January 1, 2022, the committee must annually report its findings and recommendations to the Public Health Committee.

*House Amendment "A" establishes the chronic kidney disease advisory committee.

EFFECTIVE DATE: January 1, 2022, except the chronic kidney disease advisory committee is effective upon passage.

CHRONIC KIDNEY DISEASE ADVISORY COMMITTEE

Purposes

Under the bill, the advisory committee must:

1. work with policy makers, public health organizations, and educational institutions to (a) increase awareness of the disease in Connecticut and (b) develop educational programs that reduce the burden of kidney disease, include ongoing health and wellness campaigns based on relevant research, promote preventive screenings, and are promoted through social media and public relations campaigns;
2. examine chronic kidney disease, kidney transplantation (including transplantation as a preferred treatment), living and deceased kidney donation, and racial disparities in the rates of afflicted individuals;
3. examine methods to reduce the occurrence of chronic kidney disease by controlling the most common risk factors (i.e., diabetes and hypertension) through early detection and prevention at the community level and primary care disease management;
4. identify barriers to adopting best practices and the policies available to address them;
5. develop an equitable, sustainable, cost-effective plan to raise awareness about the importance of early detection, screening, diagnosis, and treatment of chronic kidney disease and prevention; and
6. examine the potential for an opt-out organ or kidney donor registry.

Membership

Under the bill, the advisory committee consists of at least 21 required members and includes the chairs and ranking members of the Public Health Committee and the public health commissioner, or their designees. The remaining required members are appointed as follows:

1. one appointed by the House speaker who represents the renal provider community;
2. one by the Senate president pro tempore who represents a medical center with a kidney-related program;
3. one each appointed by the House and Senate majority leaders;
4. one each appointed by the House and Senate minority leaders;
5. one appointed by the governor;
6. one each appointed by the chief executive officers of the National Kidney Foundation and the American Kidney Fund;
7. one each appointed by the chairs and ranking members of the Public Health Committee; and
8. three appointed jointly by Public Health Committee chairs, one who represents the kidney physician community, one who represents a nonprofit organ procurement organization, and one who represents the Connecticut kidney patient community.

In addition to the members described above, the Public Health Committee chairs may also appoint other members they deem necessary to represent public health clinics, community health centers minority health organizations, and health insurers.

Under the bill, any of the legislatively appointed members may be General Assembly members. The appointing authorities must make initial appointments by 30 days after the bill's passage and fill any vacancies.

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

Administration

The Office of Legislative Management, in consultation with the advisory committee's chairpersons, must select committee's administrative staff.

The bill allows the advisory committee to conduct virtual meetings, at the chairpersons' discretion.

BACKGROUND

Connecticut Unfair Insurance Practices Act

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

Fines may be up to (1) \$5,000 per violation to a \$50,000 maximum or (2) \$25,000 per violation to a \$250,000 maximum in any six-month period if the violation was knowingly committed. The law also imposes a fine of up to \$50,000, in addition to or in place of a license suspension or revocation, for violating a cease and desist order (CGS § 38a-815 et seq.).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 0 (03/11/2021)