# Senate

General Assembly

**File No. 356**

***January Session, 2021***

Substitute Senate Bill No. 841

*Senate, April 8, 2021*

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDED CHANGES TO THE INSURANCE STATUTES.***

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

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 Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

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

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

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

(3) "Annuities" means all agreements to make periodical payments

where the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life or is for a specified term of years. This definition does not apply to payments made under a policy of life insurance.

(4) "Commissioner" means the Insurance Commissioner.

(5) "Control", "controlled by" or "under common control with" means the possession, direct or indirect, of the 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 commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the person.

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

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

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

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

(10) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not be limited to reserves required by statute or by regulations adopted by the commissioner in accordance with the provisions of chapter 54 or

specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

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

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

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

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

(15) "Mutual insurer" means any insurer without capital stock, the managing directors or officers of which are elected by its members.

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

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

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

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

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

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

Sec. 2. (NEW) (*Effective October 1, 2021*) No insurer, health care center or fraternal benefit society doing business in this state shall:

(1) In connection with the issuance, withholding, extension or renewal of an annuity or an insurance policy for life, credit life, disability, long-term care, accidental injury, specified disease, hospital indemnity or credit accident insurance, request, require, purchase or use information obtained from an entity providing direct-to-consumer genetic testing without the informed written consent of the individual who has been tested; or

(2) Condition insurance rates, the provision or renewal of insurance coverage or benefit or other conditions of insurance for an individual on:

(A) Any requirement or agreement that the individual undergo genetic testing; or

(B) The results of any genetic testing of a member of the individual's family unless the results are contained in the individual's medical record.

Sec. 3. Section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

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

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

(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication,

or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

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

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

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

(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the

following: (A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (B) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; (C) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; (D) refusing to pay claims without conducting a reasonable investigation based upon all available information; (E) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; (F) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; (G) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; (H) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; (I) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured; (J) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; (K) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; (L) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; (M) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; (N) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer

of a compromise settlement; (O) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy.

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

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

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

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

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

(B) (i) Subparagraph (A)(iii) of this subdivision shall not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of subparagraph (A)(ii) of this subdivision, such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required

and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required. (iii) The commissioner may investigate the affairs of any person to whom this subdivision applies to determine whether such person has violated this subdivision. If a violation of this subdivision is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of section 38a-815, subsections (b) and (e) of section 38a-817 and this section. (iv) For purposes of this section, "person" includes any individual, corporation, limited liability company, association, partnership or other legal entity.

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

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

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

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

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

(i) For claims filed in paper format, sixty days after receipt by the

insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (I) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the information requested; and

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

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

(16) Failure to pay, as part of any claim for a damaged motor vehicle under any automobile insurance policy where the vehicle has been declared to be a constructive total loss, an amount equal to the sum of (A) the settlement amount on such vehicle plus, whenever the insurer takes title to such vehicle, (B) an amount determined by multiplying such settlement amount by a percentage equivalent to the current sales

tax rate established in section 12-408. For purposes of this subdivision, "constructive total loss" means the cost to repair or salvage damaged property, or the cost to both repair and salvage such property, equals or exceeds the total value of the property at the time of the loss.

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

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

(19) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of genetic information. Genetic information indicating a predisposition to a disease or condition shall not be deemed a preexisting condition in the absence of a diagnosis of such disease or condition that is based on other

medical information. An insurance company, hospital service corporation, health care center or fraternal benefit society providing individual health coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be prohibited from refusing to insure or applying a preexisting condition limitation, to the extent permitted by law, to an individual who has been diagnosed with a disease or condition based on medical information other than genetic information and has exhibited symptoms of such disease or condition. For the purposes of this subsection, "genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

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

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

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

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

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

Sec. 4. (NEW) (*Effective July 1, 2021*) (a) (1) Except as provided in subsection (b) of this section, no insurer that delivers, issues for delivery, renews, amends or endorses a homeowners insurance policy in this state on or after July 1, 2021, that is subject to the requirements of sections 38a-663 to 38a-696, inclusive, of the general statutes shall cancel such policy unless:

(A) If such policy is not a renewal policy and has been in effect for fewer than sixty days, such insurer sends a written cancellation notice to the named insured:

(i) At least ten days before the effective date of such cancellation for nonpayment of premium disclosing:

(I) Such cancellation;

(II) That the named insured may avoid such cancellation and continue coverage under such policy by paying, before the effective date of such cancellation, such unpaid premium; and

(III) That any excess premium, if not tendered by the insurer, shall be refunded to the named insured upon demand by the named insured; or

(ii) At least thirty days before the effective date of such cancellation for any reason other than nonpayment of premium disclosing:

(I) Such cancellation;

(II) The reason for such cancellation;

(III) The effective date of such cancellation; and

(IV) That any excess premium, if not tendered by the insurer, shall be refunded to the named insured upon demand by the named insured; or

(B) If such policy is not a renewal policy and has been in effect for at least sixty days, or if such policy is an effective renewal policy, such insurer sends a written cancellation notice to the named insured:

(i) At least ten days before the effective date of such cancellation for nonpayment of premium disclosing:

(I) Such cancellation;

(II) That the named insured may avoid such cancellation and continue coverage under such policy by paying, before the effective date of such cancellation, such unpaid premium; and

(III) That any excess premium, if not tendered by the insurer, shall be refunded to the named insured upon demand by the named insured; or

(ii) At least thirty days before the effective date of such cancellation for fraud or misrepresentation of any material fact made by the named insured in obtaining coverage under such policy that, if discovered by

such insurer, would have caused such insurer not to issue or renew such policy, as applicable, or any physical change in the covered property that materially increases a hazard insured against under such policy disclosing:

(I) The effective date of such cancellation; and

(II) That any excess premium, if not tendered by the insurer, shall be refunded to the named insured upon demand by the named insured.

(2) No insurer may cancel a homeowners insurance policy described in subparagraph (B) of subdivision (1) of this subsection for any reason other than:

(A) Nonpayment of premium;

(B) Fraud or misrepresentation of any material fact made by the named insured in obtaining coverage under such policy that, if discovered by the insurer, would have caused the insurer not to issue or renew such policy, as applicable; or

(C) Any physical change in the covered property that materially increases a hazard insured against under such policy.

(3) No notice of cancellation required under subdivision (1) of this subsection shall be effective unless such notice is sent to the named insured by registered mail, certified mail or mail evidenced by a certificate of mailing, or, if agreed by the insurer and the named insured, by electronic means evidenced by a delivery receipt.

(b) No notice of cancellation is required under subsection (a) of this section if the homeowners insurance policy is transferred from the insurer to an affiliate of such insurer for another policy with no interruption of coverage and the same terms, conditions and provisions, including policy limits, as the transferred policy, except that the insurer to which the policy is transferred shall not be prohibited from applying such insurer's rates and rating plans at the time of renewal.

(c) The named insured under a homeowners insurance policy described in subsection (a) of this section may cancel such policy at any time by sending to the insurer that delivered, issued for delivery, renewed, amended or endorsed such policy a written notice disclosing the effective date of such cancellation.

Sec. 5. Section 38a-646 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

As used in sections 38a-645 to 38a-658, inclusive, except as otherwise provided herein:

(1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction;

(2) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(3) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;

(4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction;

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction; **[**.**]** and

(6) "Loss ratio" means annual incurred claims divided by earned premiums.

Sec. 6. Subsection (b) of section 38a-651 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54, establishing a procedure for review of such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders, and shall disapprove any such form at any time if: **[**the**]**

(1) The schedule of premium rates charged or to be charged is, by reasonable assumptions and as determined according to benchmark loss ratio calculations, excessive in relation to the benefits provided; or **[**if it contains**]**

(2) Such form:

(A) Has a prima facie loss ratio of less than fifty per cent for any single or joint credit life insurance or credit accident and health insurance policy unless the commissioner approves a premium rate deviation for such policy; or

(B) Contains provisions which (i) are unjust, unfair, inequitable, misleading, deceptive, **[**or which**]** (ii) encourage misrepresentation of the coverage, or **[**which**]** (iii) are contrary to any provision of the insurance laws or of any rule or regulation promulgated thereunder.

Sec. 7. Subsection (e) of section 38a-702e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(e) Each applicant for an insurance producer license shall, before being admitted to an examination under subsection (a) of this section, prove to the satisfaction of the commissioner that such applicant meets one of the following prerequisites: (1) Successful completion of a course approved by the commissioner requiring not less than **[**forty**]** twenty hours for each line of insurance for which the applicant is applying to be licensed; or (2) equivalent experience or training as determined by

549 the commissioner.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *October 1, 2021* | 38a-1 |
| Sec. 2 | *October 1, 2021* | New section |
| Sec. 3 | *October 1, 2021* | 38a-816 |
| Sec. 4 | *July 1, 2021* | New section |
| Sec. 5 | *October 1, 2021* | 38a-646 |
| Sec. 6 | *October 1, 2021* | 38a-651(b) |
| Sec. 7 | *October 1, 2021* | 38a-702e(e) |

***Statement of Legislative Commissioners:***
In Section 1, "sections 2 and 4" was substituted for "section 2" for consistency.

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

Note: GF=General Fund

### *Municipal Impact:* None

### *Explanation*

The bill results in a potential minimal revenue gain to the General Fund to the extent additional fines or penalties are assessed for violations of the Connecticut Unfair Insurance Practices Act (CUIPA). The bill prohibits certain actions by insurers related to genetic testing results 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 entity in any six-month period.

The remaining provisions of the bill are not anticipated to result in a fiscal impact as they (1) codify existing Insurance Department administrative policy for homeowner insurance policy cancellations, (2) require the Commissioner to include a benchmark loss ratio in credit insurance rate reviews, and (3) reduce hours of study, but no fees paid to the state, for insurance producer licensing.

### *The Out Years*

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

*Sources: Connecticut Insurance Department*

**OLR Bill Analysis**

**SB 841**

***AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDED CHANGES TO THE INSURANCE STATUTES.***

## SUMMARY

This bill makes a number of unrelated changes to the insurance statutes concerning (1) insurers' use of genetic testing results, (2) the cancellation of homeowners insurance policies, (3) loss ratio requirements for credit insurance policies, and (4) insurance producer prelicensure education requirements.

The bill prohibits certain insurance entities from requesting, requiring, purchasing, or using direct-to-consumer genetic testing results without the tested individual's written consent. It also prohibits the entities from conditioning rates, coverage, or other insurance terms on (1) an individual undergoing genetic testing or (2) the genetic testing results of the individual's family members unless the results are in his or her medical records. The bill makes a violation of these provisions a Connecticut Unfair Insurance Practices Act (CUIPA) violation (see BACKGROUND) (§§ 1-3).

The bill codifies existing Insurance Department administrative policy for homeowners insurance policy cancellations. It requires insurers to notify consumers of a cancellation, establishes the cancellation process and timeframes, and specifies permissible cancellation reasons (§ 4).

The bill establishes a loss ratio requirement for credit life and credit accident and health insurance policies of at least 50% (§§ 5 & 6). Under the bill, "loss ratio" means annual incurred claims divided by earned premiums.

Lastly, the bill reduces the number of hours of course study an

insurance producer license applicant must complete before sitting for a license examination from 40 hours to 20 hours (§ 7). This conforms with the National Association of Insurance Commissioners' uniform licensing standards.

EFFECTIVE DATE: October 1, 2021, except the provisions on the cancellation of homeowners insurance policies are effective July 1, 2021.

## §§ 1-3 – GENETIC TESTING RESULTS

The bill prohibits insurers, health care centers (i.e., HMOs), and fraternal benefit societies from requesting, requiring, purchasing, or using direct-to-consumer genetic testing results without the tested individual's written consent. This applies with respect to the issuance, withholding, extension, or renewal of annuities and life, credit life or accident, disability, long-term care, accidental injury, specified disease, and hospital indemnity insurance policies.

The bill also prohibits insurers, HMOs, and fraternal benefit societies from conditioning rates, the issuance or renewal of coverage or benefits, or other insurance terms on (1) a requirement or agreement that an individual undergo genetic testing or (2) the genetic testing results of the individual's family members unless the results are in his or her medical records.

The bill makes a violation of the above a CUIPA violation (see BACKGROUND).

CUIPA already prohibits insurers, HMOs, and fraternal benefit societies that issue health insurance policies from refusing to insure, limiting coverage, or charging a different rate based on genetic information (CGS § 38a-816(19)).

## § 4 – HOMEOWNERS INSURANCE CANCELLATION

The bill codifies existing Insurance Department administrative policy for homeowners insurance policy cancellations. It outlines the process and timeframes for insurers to notify consumers of a cancellation and specifies the permissible cancellation reasons.

### *Cancellation Process, Timeframes, and Reasons*

Under the bill, if the insurer wants to cancel a policy for premium nonpayment, the insurer must send a written cancellation notice to the named insured at least 10 days before the cancellation effective date. The notice must disclose that the insured can avoid cancellation by paying the premium before the cancellation effective date and that any excess premium will be refunded to the insured upon request.

If a policy is not a renewal policy and has been in effect for fewer than 60 days, and the insurer wants to cancel it for a reason other than premium nonpayment, the insurer must send a written cancellation notice to the named insured at least 30 days before the cancellation effective date. The notice must disclose the cancellation reason, the cancellation effective date, and that any excess premium will be refunded to the insured upon request.

If a policy is not a renewal policy and has been in effect for at least 60 days or is a renewal policy, and the insurer wants to cancel it for either (1) fraud or misrepresentation of a material fact by the insured in obtaining the insurance that would have caused the insurer to not issue or renew the policy or (2) any physical change in the covered property that materially increases a hazard insured against, then the insurer must send a written cancellation notice to the named insured at least 30 days before the cancellation effective date. The notice must include the cancellation effective date and that any excess premium will be refunded to the insured upon request. (Under the bill, an insurer may only cancel such a policy for these specified reasons or premium nonpayment.)

### *Cancellation Method*

Under the bill, a homeowners insurance policy cancellation notice is effective only if the insurer sends it to the named insured by registered or certified mail or mail evidenced by a certificate of mailing. But if the insured agrees, the insurer may send a cancellation notice electronically and evidenced by a delivery receipt.

### *Policy Transfer to Affiliate*

Under the bill, an insurer does not have to issue a cancellation notice if it transfers a policy to an affiliate with no interruption of coverage and no changes in coverage terms. However, the new insurer may apply its rates and rating plans at renewal.

### *Insured May Cancel Anytime in Writing*

The bill specifies that a named insured under a homeowners insurance policy may cancel the policy anytime by sending the insurer a written notice with the cancellation effective date.

## §§ 5 & 6 – LOSS RATIO REQUIREMENT FOR CREDIT INSURANCE

The bill establishes a loss ratio requirement for credit life and credit accident and health insurance policies of at least 50%.

Under current law, the insurance commissioner must disapprove a credit insurance policy form (e.g., policy, certificate, application, rider) if the rates charged, by reasonable assumptions, are excessive in relation to the benefits provided. The bill instead requires him to disapprove a policy form if the rates charged, by reasonable assumptions and as determined according to benchmark loss ratio calculations, are excessive in relation to the benefits provided.

The bill also requires the commissioner to disapprove a policy form that does not comply with the loss ratio requirement. However, he may approve a premium rate deviation for a policy, presumably resulting in a lower loss ratio.

The bill requires the commissioner to adopt regulations that reflect the above requirements.

## BACKGROUND

### *Connecticut Unfair Insurance Practices Act*

The law prohibits engaging in unfair or deceptive acts or practices in the business of insurance. It authorizes the insurance commissioner to conduct investigations and hearings, issue cease and desist orders, impose fines, revoke or suspend licenses, and order restitution for per

se violations (i.e., violations specifically listed in statute). The law also allows the commissioner to ask the attorney general to seek injunctive relief in Superior Court if he believes someone is engaging in other unfair or deceptive acts not specifically defined in statute.

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

## COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 18 Nay 0 (03/22/2021)