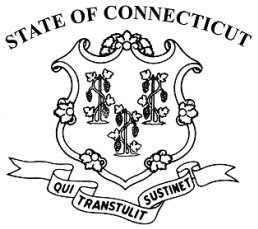


***House Bill No. 6590***

# *Public Act No. 21-93*

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

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

Section 1. Section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):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**]** subdivision "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, as amended by this act, 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), (5), (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**]** domestic violence, as defined in section 17b-112a.

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

**[**(19)**]** (20) 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**]** subdivision, "genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

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

**[**(21)**]** (22) 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)**]** (23) Any violation of sections 38a-591d to 38a-591f, inclusive.

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

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 Section 38a-447 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

No life insurance company doing business in this state may: (1) Make any distinction or discrimination between persons on the basis of race, sexual orientation, gender identity or status as a victim of domestic violence as to the premiums or rates charged for policies upon the lives of such persons; (2) demand or require greater premiums from persons of one race, sexual orientation or gender identity than such as are at that time required by that company from persons of another race, sexual orientation or gender identity, or persons who have been victims of domestic violence than such as are at that time required by that company from persons who have not been victims of domestic violence, of the same age, sex, general condition of health and hope of longevity; or (3) make or require any rebate, diminution or discount on the basis of race, sexual orientation, gender identity or status as a victim of domestic violence upon the sum to be paid on any policy in case of the death of any person insured, nor insert in the policy any condition, nor make any stipulation whereby such person insured shall bind **[**himself, his**]** such person, such person's heirs, executors, administrators or assigns to accept any sum less than the full value or amount of such policy, in case of a claim accruing thereon by reason of the death of such person insured, other than such as are imposed upon all persons in similar cases; and each such stipulation or condition so made or inserted shall be void. For the purposes of this section, "victim of domestic violence" has the same meaning as provided in section 17b-112a.

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

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

(1) "Advertisement" means any written, electronic or printed

communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet or similar communications media, including, but not limited to, film strips, motion pictures and videos, published, disseminated, circulated or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a life settlement contract.

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

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

(4) "Chronically ill" means: (A) Being unable to perform at least two activities of daily living, including, but not limited to, eating, toileting, transferring, bathing, dressing or continence; (B) requiring substantial supervision to protect from threats to health and safety due to severe cognitive impairment; or (C) having a level of disability similar to that described in subparagraph (A) of this subdivision as determined by the federal Secretary of Health and Human Services.

(5) "Commissioner" means the Insurance Commissioner.

(6) (A) "Financing entity" means an underwriter, placement agent,

lender, purchaser of securities, purchaser of a policy or certificate from a provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

rider;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) A purchaser;

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

(G) A financing entity;

(H) A special purpose entity;

(I) A related provider trust;

(J) A broker; or

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

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

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

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

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

(23) "Special purpose entity" means a corporation, partnership, trust, limited liability company or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets (A) for a financing entity or provider, (B) in connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a qualified institutional buyer, as defined in Rule 144A of the federal Securities Act of 1933, as amended from time

to time, or (C) the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) The administrative staff of the joint standing committee of the

General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the task force.

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