



General Assembly

February Session, 2008

Raised Bill No. 482

LCO No. 2251

02251_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING HEALTH CARE CLAIMS.

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

1 Section 1. (NEW) (*Effective January 1, 2009*) No contract between an
2 insurer, including a dental or vision carrier, and a participating
3 provider shall include or offer any incentive, monetary or otherwise, to
4 the participating provider as an inducement to change a prescription
5 for a drug or medical product issued to an insured from one specific
6 drug or medical product to another. Nothing in this section shall be
7 construed to prohibit an incentive plan that does not make reference to
8 a specific prescription drug or medical product.

9 Sec. 2. Section 38a-816 of the general statutes is repealed and the
10 following is substituted in lieu thereof (*Effective January 1, 2009*):

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

13 (1) Misrepresentations and false advertising of insurance policies.
14 Making, issuing or circulating, or causing to be made, issued or
15 circulated, any estimate, illustration, circular or statement, sales

16 presentation, omission or comparison which: (a) Misrepresents the
17 benefits, advantages, conditions or terms of any insurance policy; (b)
18 misrepresents the dividends or share of the surplus to be received, on
19 any insurance policy; (c) makes any false or misleading statements as
20 to the dividends or share of surplus previously paid on any insurance
21 policy; (d) is misleading or is a misrepresentation as to the financial
22 condition of any person, or as to the legal reserve system upon which
23 any life insurer operates; (e) uses any name or title of any insurance
24 policy or class of insurance policies misrepresenting the true nature
25 thereof; (f) is a misrepresentation, including, but not limited to, an
26 intentional misquote of a premium rate, for the purpose of inducing or
27 tending to induce to the purchase, lapse, forfeiture, exchange,
28 conversion or surrender of any insurance policy; (g) is a
29 misrepresentation for the purpose of effecting a pledge or assignment
30 of or effecting a loan against any insurance policy; or (h) misrepresents
31 any insurance policy as being shares of stock.

32 (2) False information and advertising generally. Making, publishing,
33 disseminating, circulating or placing before the public, or causing,
34 directly or indirectly, to be made, published, disseminated, circulated
35 or placed before the public, in a newspaper, magazine or other
36 publication, or in the form of a notice, circular, pamphlet, letter or
37 poster, or over any radio or television station, or in any other way, an
38 advertisement, announcement or statement containing any assertion,
39 representation or statement with respect to the business of insurance
40 or with respect to any person in the conduct of his insurance business,
41 which is untrue, deceptive or misleading.

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

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

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

67 (6) Unfair claim settlement practices. Committing or performing
68 with such frequency as to indicate a general business practice any of
69 the following: (a) Misrepresenting pertinent facts or insurance policy
70 provisions relating to coverages at issue; (b) failing to acknowledge
71 and act with reasonable promptness upon communications with
72 respect to claims arising under insurance policies; (c) failing to adopt
73 and implement reasonable standards for the prompt investigation of
74 claims arising under insurance policies; (d) refusing to pay claims
75 without conducting a reasonable investigation based upon all available
76 information; (e) failing to affirm or deny coverage of claims within a
77 reasonable time after proof of loss statements have been completed; (f)
78 not attempting in good faith to effectuate prompt, fair and equitable
79 settlements of claims in which liability has become reasonably clear;
80 (g) compelling insureds to institute litigation to recover amounts due
81 under an insurance policy by offering substantially less than the

82 amounts ultimately recovered in actions brought by such insureds; (h)
83 attempting to settle a claim for less than the amount to which a
84 reasonable man would have believed he was entitled by reference to
85 written or printed advertising material accompanying or made part of
86 an application; (i) attempting to settle claims on the basis of an
87 application which was altered without notice to, or knowledge or
88 consent of the insured; (j) making claims payments to insureds or
89 beneficiaries not accompanied by statements setting forth the coverage
90 under which the payments are being made; (k) making known to
91 insureds or claimants a policy of appealing from arbitration awards in
92 favor of insureds or claimants for the purpose of compelling them to
93 accept settlements or compromises less than the amount awarded in
94 arbitration; (l) delaying the investigation or payment of claims by
95 requiring an insured, claimant, or the physician of either to submit a
96 preliminary claim report and then requiring the subsequent
97 submission of formal proof of loss forms, both of which submissions
98 contain substantially the same information; (m) failing to promptly
99 settle claims, where liability has become reasonably clear, under one
100 portion of the insurance policy coverage in order to influence
101 settlements under other portions of the insurance policy coverage; (n)
102 failing to promptly provide a reasonable explanation of the basis in the
103 insurance policy in relation to the facts or applicable law for denial of a
104 claim or for the offer of a compromise settlement; (o) using as a basis
105 for cash settlement with a first party automobile insurance claimant an
106 amount which is less than the amount which the insurer would pay if
107 repairs were made unless such amount is agreed to by the insured or
108 provided for by the insurance policy.

109 (7) Failure to maintain complaint handling procedures. Failure of
110 any person to maintain complete record of all the complaints which it
111 has received since the date of its last examination. This record shall
112 indicate the total number of complaints, their classification by line of
113 insurance, the nature of each complaint, the disposition of these
114 complaints, and the time it took to process each complaint. For
115 purposes of this subsection "complaint" shall mean any written

116 communication primarily expressing a grievance.

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

122 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447,
123 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following
124 practices shall be considered discrimination within the meaning of
125 section 38a-446 or 38a-488 or a rebate within the meaning of section
126 38a-825: (a) Paying bonuses to policyholders or otherwise abating their
127 premiums in whole or in part out of surplus accumulated from
128 nonparticipating insurance, provided any such bonuses or abatement
129 of premiums shall be fair and equitable to policyholders and for the
130 best interests of the company and its policyholders; (b) in the case of
131 policies issued on the industrial debit plan, making allowance to
132 policyholders who have continuously for a specified period made
133 premium payments directly to an office of the insurer in an amount
134 which fairly represents the saving in collection expense; (c)
135 readjustment of the rate of premium for a group insurance policy
136 based on loss or expense experience, or both, at the end of the first or
137 any subsequent policy year, which may be made retroactive for such
138 policy year.

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

148 (11) Favored agent or insurer: Coercion of debtors. (a) No person
149 [may] shall (i) require, as a condition precedent to the lending of
150 money or extension of credit, or any renewal thereof, that the person to
151 whom such money or credit is extended or whose obligation the
152 creditor is to acquire or finance, negotiate any policy or contract of
153 insurance through a particular insurer or group of insurers or
154 producer or group of producers; (ii) unreasonably disapprove the
155 insurance policy provided by a borrower for the protection of the
156 property securing the credit or lien; (iii) require directly or indirectly
157 that any borrower, mortgagor, purchaser, insurer or producer pay a
158 separate charge, in connection with the handling of any insurance
159 policy required as security for a loan on real estate or pay a separate
160 charge to substitute the insurance policy of one insurer for that of
161 another; or (iv) use or disclose information resulting from a
162 requirement that a borrower, mortgagor or purchaser furnish
163 insurance of any kind on real property being conveyed or used as
164 collateral security to a loan, when such information is to the advantage
165 of the mortgagee, vendor or lender, or is to the detriment of the
166 borrower, mortgagor, purchaser, insurer or the producer complying
167 with such a requirement. (b)(i) Subsection (a)(iii) does not include the
168 interest which may be charged on premium loans or premium
169 advancements in accordance with the security instrument. (ii) For
170 purposes of subsection (a)(ii), such disapproval shall be deemed
171 unreasonable if it is not based solely on reasonable standards
172 uniformly applied, relating to the extent of coverage required and the
173 financial soundness and the services of an insurer. Such standards
174 shall not discriminate against any particular type of insurer, nor shall
175 such standards call for the disapproval of an insurance policy because
176 such policy contains coverage in addition to that required. (iii) The
177 commissioner may investigate the affairs of any person to whom this
178 subsection applies to determine whether such person has violated this
179 subsection. If a violation of this subsection is found, the person in
180 violation shall be subject to the same procedures and penalties as are
181 applicable to other provisions of section 38a-815, subsections (b) and

182 (e) of section 38a-817 and this section. (iv) For purposes of this section,
183 "person" includes any individual, corporation, limited liability
184 company, association, partnership or other legal entity.

185 (12) Refusing to insure, refusing to continue to insure or limiting the
186 amount, extent or kind of coverage available to an individual or
187 charging an individual a different rate for the same coverage because
188 of physical disability or mental retardation, except where the refusal,
189 limitation or rate differential is based on sound actuarial principles or
190 is related to actual or reasonably anticipated experience.

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

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

210 (15) (A) Failure by an insurer, or any other entity responsible for
211 providing payment to a health care provider pursuant to an insurance
212 policy, to pay accident and health claims, including, but not limited to,
213 claims for payment or reimbursement to health care providers, within

214 the time periods set forth in subparagraph (B) of this subdivision,
215 unless the Insurance Commissioner determines that a legitimate
216 dispute exists as to coverage, liability or damages or that the claimant
217 has fraudulently caused or contributed to the loss. Any insurer, or any
218 other entity responsible for providing payment to a health care
219 provider pursuant to an insurance policy, who fails to pay such a claim
220 or request within the time periods set forth in subparagraph (B) of this
221 subdivision shall pay the claimant or health care provider the amount
222 of such claim plus interest at the rate of fifteen per cent per annum, in
223 addition to any other penalties which may be imposed pursuant to
224 sections 38a-11 of the 2008 supplement to the general statutes, 38a-25,
225 38a-41 to 38a-53, inclusive, of the 2008 supplement to the general
226 statutes, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-76,
227 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140,
228 inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290,
229 inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
230 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
231 inclusive. Whenever the interest due a claimant or health care provider
232 pursuant to this section is less than one dollar, the insurer shall deposit
233 such amount in a separate interest-bearing account in which all such
234 amounts shall be deposited. At the end of each calendar year each such
235 insurer shall donate such amount to The University of Connecticut
236 Health Center.

237 (B) Each insurer, or other entity responsible for providing payment
238 to a health care provider pursuant to an insurance policy subject to this
239 section, shall pay claims not later than forty-five days after receipt by
240 the insurer of the claimant's proof of loss form or the health care
241 provider's request for payment filed in accordance with the insurer's
242 practices or procedures, except that when there is a deficiency in the
243 information needed for processing a claim, as determined in
244 accordance with section 38a-477, the insurer shall (i) send written
245 notice to the claimant or health care provider, as the case may be, of all
246 alleged deficiencies in information needed for processing a claim not
247 later than thirty days after the insurer receives a claim for payment or

248 reimbursement under the contract, and (ii) pay claims for payment or
249 reimbursement under the contract not later than thirty days after the
250 insurer receives the information requested.

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

255 (16) Failure to pay, as part of any claim for a damaged motor vehicle
256 under any automobile insurance policy where the vehicle has been
257 declared to be a constructive total loss, an amount equal to the sum of
258 (A) the settlement amount on such vehicle plus, whenever the insurer
259 takes title to such vehicle, (B) an amount determined by multiplying
260 such settlement amount by a percentage equivalent to the current sales
261 tax rate established in section 12-408. For purposes of this subdivision,
262 "constructive total loss" means the cost to repair or salvage damaged
263 property, or the cost to both repair and salvage such property, equals
264 or exceeds the total value of the property at the time of the loss.

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

276 (18) With respect to an insurance company, hospital service
277 corporation, health care center or fraternal benefit society providing
278 individual or group health insurance coverage of the types specified in
279 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469,

280 refusing to insure, refusing to continue to insure or limiting the
281 amount, extent or kind of coverage available to an individual or
282 charging an individual a different rate for the same coverage because
283 such individual has been a victim of family violence.

284 (19) With respect to an insurance company, hospital service
285 corporation, health care center or fraternal benefit society providing
286 individual or group health insurance coverage of the types specified in
287 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-
288 469, refusing to insure, refusing to continue to insure or limiting the
289 amount, extent or kind of coverage available to an individual or
290 charging an individual a different rate for the same coverage because
291 of genetic information. Genetic information indicating a predisposition
292 to a disease or condition shall not be deemed a preexisting condition in
293 the absence of a diagnosis of such disease or condition that is based on
294 other medical information. An insurance company, hospital service
295 corporation, health care center or fraternal benefit society providing
296 individual health coverage of the types specified in subdivisions (1),
297 (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be
298 prohibited from refusing to insure or applying a preexisting condition
299 limitation, to the extent permitted by law, to an individual who has
300 been diagnosed with a disease or condition based on medical
301 information other than genetic information and has exhibited
302 symptoms of such disease or condition. For the purposes of this
303 subsection, "genetic information" means the information about genes,
304 gene products or inherited characteristics that may derive from an
305 individual or family member.

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

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

310 (22) Any violation of section 38a-478m.

311 (23) With respect to an insurance company, hospital service
312 corporation, health care center or fraternal benefit society providing
313 individual or group health insurance coverage of the types specified in
314 section 38a-469, offering or providing any incentive, financial or
315 otherwise, to any person for denying enrollees' health care claims or
316 based on the number of denials such person makes.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2009</i>	New section
Sec. 2	<i>January 1, 2009</i>	38a-816

Statement of Purpose:

To make it an unfair insurance practice for health insurance companies in Connecticut to provide incentives, financial or otherwise, to deny its enrollees' health care claims, and to prohibit insurers from offering incentives to providers to switch to a specific drug or medical product offering.

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