



General Assembly

**Amendment**

January Session, 2009

LCO No. 7150

\*SB0066407150SDO\*

Offered by:

SEN. PRAGUE, 19<sup>th</sup> Dist.

SEN. SLOSSBERG, 14<sup>th</sup> Dist.

To: Subst. Senate Bill No. 664

File No. 243

Cal. No. 226

**"AN ACT CONCERNING BILLING FOR ASSISTED LIVING SERVICES COVERED BY LONG-TERM CARE INSURANCE."**

1 Strike everything after the enacting clause and substitute the  
2 following in lieu thereof:

3 "Section 1. Section 19a-693 of the general statutes is repealed and the  
4 following is substituted in lieu thereof (*Effective July 1, 2009*):

5 As used in this section and sections 19a-694 to 19a-701, inclusive, as  
6 amended by this act:

7 (1) "Activities of daily living" means activities or tasks that are  
8 essential for a person's healthful and safe existence, including, but not  
9 limited to, bathing, dressing, grooming, eating, meal preparation,  
10 shopping, housekeeping, transfers, bowel and bladder care, laundry,  
11 communication, self-administration of medication and ambulation.

12 (2) "Assisted living services" means nursing services and assistance  
13 with activities of daily living provided to residents living within a

14 managed residential community having supportive services that  
15 encourage persons primarily fifty-five years of age or older to maintain  
16 a maximum level of independence.

17 (3) "Assisted living services agency" means an entity, licensed by the  
18 Department of Public Health pursuant to chapter 368v that provides,  
19 among other things, nursing services and assistance with activities of  
20 daily living to a population that is chronic and stable.

21 (4) "Managed residential community" means a for-profit or not-for-  
22 profit facility consisting of private residential units that provides a  
23 managed group living environment consisting of housing and services  
24 for persons who are primarily fifty-five years of age or older.  
25 "Managed residential community" does not include any state-funded  
26 congregate housing facilities.

27 (5) "Department" means the Department of Public Health.

28 (6) "Private residential unit" means a private living environment  
29 designed for use and occupancy by a resident within a managed  
30 residential community that includes a full bathroom and access to  
31 facilities and equipment for the preparation and storage of food.

32 (7) "Resident" means a person residing in a private residential unit  
33 of a managed residential community pursuant to the terms of a written  
34 agreement for occupancy of such unit.

35 (8) "Assignment of benefits" means the transfer of the right to  
36 receive payment due under a long-term care policy, as defined in  
37 subsection (a) of section 38a-501, as amended by this act, by a resident  
38 to a managed residential community or an assisted living services  
39 agency.

40 (9) "Assignment of benefits election form" means a written  
41 instrument by which a resident makes an assignment of benefits.

42 Sec. 2. Section 19a-694 of the general statutes is repealed and the  
43 following is substituted in lieu thereof (*Effective July 1, 2009*):

44 (a) All managed residential communities operating in the state shall:

45 (1) Provide a written residency agreement to each resident in  
46 accordance with section 19a-700, as amended by this act;

47 (2) Afford residents the ability to access services provided by an  
48 assisted living services agency. Such services shall be provided in  
49 accordance with a service plan developed in accordance with section  
50 19a-699;

51 (3) Upon the request of a resident, arrange, in conjunction with the  
52 assisted living services agency, for the provision of ancillary medical  
53 services on behalf of a resident, including physician and dental  
54 services, pharmacy services, restorative physical therapies, podiatry  
55 services, hospice care and home health agency services, provided the  
56 ancillary medical services are not administered by employees of the  
57 managed residential community, unless the resident chooses to receive  
58 such services;

59 (4) Provide a formally established security program for the  
60 protection and safety of residents that is designed to protect residents  
61 from intruders;

62 (5) Afford residents the rights and privileges guaranteed under title  
63 47a;

64 (6) Comply with the provisions of subsection (c) of section 19-13-  
65 D105 of the regulations of Connecticut state agencies; and

66 (7) Be subject to oversight and regulation by the Department of  
67 Public Health.

68 (b) No managed residential community shall control or manage the  
69 financial affairs or personal property of any resident, except as  
70 provided for in subsection (c) of this section.

71 (c) (1) A resident who has a long-term care policy may elect to have  
72 the managed residential community bill the insurer directly by

73 submitting an assignment of benefits election form executed by the  
74 resident or the resident's legal representative to such managed  
75 residential community. If the resident submits an assignment of  
76 benefits election form pursuant to this subdivision, such managed  
77 residential community shall submit such assignment of benefits  
78 election form to the insurer and shall bill the insurer directly.

79 (2) If an insurer remits payment pursuant to a resident's assignment  
80 of benefits under subdivision (1) of this subsection to a managed  
81 residential community in excess of the cost for the resident's housing  
82 and services provided by such managed residential community, such  
83 managed residential community shall give such excess to such  
84 resident.

85 Sec. 3. Section 19a-700 of the general statutes is repealed and the  
86 following is substituted in lieu thereof (*Effective July 1, 2009*):

87 A managed residential community shall enter into a written  
88 residency agreement with each resident that clearly sets forth the  
89 rights and responsibilities of the resident and the managed residential  
90 community, including the duties set forth in section 19a-562. The  
91 residency agreement shall be set forth in plain language and printed in  
92 not less than fourteen-point type. The residency agreement shall be  
93 signed by the managed residential community's authorized agent and  
94 by the resident, or the resident's legal representative, prior to the  
95 resident taking possession of a private residential unit and shall  
96 include, at a minimum:

97 (1) An itemization of assisted living services, transportation  
98 services, recreation services and any other services and goods, lodging  
99 and meals to be provided on behalf of the resident by the managed  
100 residential community;

101 (2) A full and fair disclosure of all charges, fees, expenses and costs  
102 to be borne by the resident;

103 (3) A schedule of payments and disclosure of all late fees or

104 potential penalties;

105 (4) The grievance procedure with respect to enforcement of the  
106 terms of the residency agreement;

107 (5) The managed residential community's covenant to comply with  
108 all municipal, state and federal laws and regulations regarding  
109 consumer protection and protection from financial exploitation;

110 (6) The managed residential community's covenant to afford  
111 residents all rights and privileges afforded under title 47a;

112 (7) The conditions under which the agreement can be terminated by  
113 either party;

114 (8) Full disclosure of the rights and responsibilities of the resident  
115 and the managed residential community in situations involving  
116 serious deterioration in the health of the resident, hospitalization of the  
117 resident or death of the resident, including a provision that specifies  
118 that in the event that a resident of the community dies, the estate or  
119 family of such resident shall only be responsible for further payment to  
120 the community for a period of time not to exceed fifteen days  
121 following the date of death of such resident as long as the private  
122 residential unit formerly occupied by the resident has been vacated;  
123 [and]

124 (9) Any adopted rules of the managed residential community  
125 reasonably designed to promote the health, safety and welfare of  
126 residents; and

127 (10) An assignment of benefits election form.

128 Sec. 4. Section 19a-699 of the general statutes is repealed and the  
129 following is substituted in lieu thereof (*Effective July 1, 2009*):

130 (a) An assisted living services agency shall develop and maintain an  
131 individualized service plan for any resident of a managed residential  
132 community that receives assisted living services. Such agency shall

133 develop the individualized service plan after consultation with the  
134 resident and following an assessment of the resident by a registered  
135 nurse. The individualized service plan shall set forth in lay terms the  
136 needs of the resident for assisted living services, the providers or  
137 intended providers of needed services, the scope, type and frequency  
138 of such services, an itemized cost of such services and any other  
139 information that Department of Public Health may require. The  
140 individualized service plan and any periodic revisions thereto shall be  
141 confidential, in writing, signed by the resident, or the resident's legal  
142 representative, and a representative of the assisted living services  
143 agency and available for inspection by the resident and the  
144 department. The assisted living services agency shall also provide the  
145 resident or the resident's legal representative with an assignment of  
146 benefits election form.

147 (b) An assisted living services agency shall maintain written policies  
148 and procedures for the initial evaluation and regular, periodic  
149 reassessment of the functional and health status and service  
150 requirements of each resident who requires assisted living services.

151 (c) (1) A resident who has a long-term care policy may elect to have  
152 the assisted living services agency bill the insurer directly by  
153 submitting an assignment of benefits election form executed by the  
154 resident or the resident's legal representative to such assisted living  
155 services agency. If the resident submits an assignment of benefits  
156 election form pursuant to this subdivision, such assisted living services  
157 agency shall submit such assignment of benefits election form to the  
158 insurer and shall bill the insurer directly.

159 (2) If an insurer remits payment pursuant to a resident's assignment  
160 of benefits under subdivision (1) of this subsection to an assisted living  
161 services agency in excess of the cost for the resident's housing and  
162 services provided by such assisted living services agency, such assisted  
163 living services agency shall give such excess to such resident.

164 Sec. 5. Subsection (a) of section 38a-501 of the general statutes is

165 repealed and the following is substituted in lieu thereof (*Effective July*  
166 *1, 2009*):

167 (a) (1) As used in this section, "long-term care policy" means any  
168 individual health insurance policy, delivered or issued for delivery to  
169 any resident of this state on or after July 1, 1986, which is designed to  
170 provide, within the terms and conditions of the policy, benefits on an  
171 expense-incurred, indemnity or prepaid basis for necessary care or  
172 treatment of an injury, illness or loss of functional capacity provided  
173 by a certified or licensed health care provider in a setting other than an  
174 acute care hospital, for at least one year after an elimination period  
175 ~~[(1)] (A)~~ not to exceed one hundred days of confinement, or ~~[(2)] (B)~~ of  
176 over one hundred days but not to exceed two years of confinement,  
177 provided such period is covered by an irrevocable trust in an amount  
178 estimated to be sufficient to furnish coverage to the grantor of the trust  
179 for the duration of the elimination period. Such trust shall create an  
180 unconditional duty to pay the full amount held in trust exclusively to  
181 cover the costs of confinement during the elimination period, subject  
182 only to taxes and any trustee's charges allowed by law. Payment shall  
183 be made directly to the provider. The duty of the trustee may be  
184 enforced by the state, the grantor or any person acting on behalf of the  
185 grantor. A long-term care policy shall provide benefits for confinement  
186 in a nursing home or confinement in the insured's own home or both.  
187 Any additional benefits provided shall be related to long-term  
188 treatment of an injury, illness or loss of functional capacity. "Long-term  
189 care policy" shall not include any such policy which is offered  
190 primarily to provide basic Medicare supplement coverage, basic  
191 medical-surgical expense coverage, hospital confinement indemnity  
192 coverage, major medical expense coverage, disability income  
193 protection coverage, accident only coverage, specified accident  
194 coverage or limited benefit health coverage.

195 (2) No insurance company, fraternal benefit society, hospital service  
196 corporation, medical service corporation or health care center  
197 delivering, issuing for delivery, renewing, continuing or amending any  
198 long-term care policy in this state may refuse to honor an assignment

199 of benefits, as defined in section 19a-693, as amended by this act, made  
200 by the insured. The insurer shall process any claim or bill submitted  
201 pursuant to subsection (c) of section 19a-694, as amended by this act,  
202 or subsection (c) of section 19a-699, as amended by this act, in  
203 accordance with such insurer's claim practices and pay benefits due  
204 under such policy directly to the managed residential community or  
205 the assisted living services agency, as the case may be.

206 Sec. 6. Section 38a-816 of the general statutes is repealed and the  
207 following is substituted in lieu thereof (*Effective July 1, 2009*):

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

210 (1) Misrepresentations and false advertising of insurance policies.  
211 Making, issuing or circulating, or causing to be made, issued or  
212 circulated, any estimate, illustration, circular or statement, sales  
213 presentation, omission or comparison which: [(a)] (A) Misrepresents  
214 the benefits, advantages, conditions or terms of any insurance policy;  
215 [(b)] (B) misrepresents the dividends or share of the surplus to be  
216 received, on any insurance policy; [(c)] (C) makes any false or  
217 misleading statements as to the dividends or share of surplus  
218 previously paid on any insurance policy; [(d)] (D) is misleading or is a  
219 misrepresentation as to the financial condition of any person, or as to  
220 the legal reserve system upon which any life insurer operates; [(e)] (E)  
221 uses any name or title of any insurance policy or class of insurance  
222 policies misrepresenting the true nature thereof; [(f)] (F) is a  
223 misrepresentation, including, but not limited to, an intentional  
224 misquote of a premium rate, for the purpose of inducing or tending to  
225 induce to the purchase, lapse, forfeiture, exchange, conversion or  
226 surrender of any insurance policy; [(g)] (G) is a misrepresentation for  
227 the purpose of effecting a pledge or assignment of or effecting a loan  
228 against any insurance policy; or [(h)] (H) misrepresents any insurance  
229 policy as being shares of stock.

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

231 disseminating, circulating or placing before the public, or causing,  
232 directly or indirectly, to be made, published, disseminated, circulated  
233 or placed before the public, in a newspaper, magazine or other  
234 publication, or in the form of a notice, circular, pamphlet, letter or  
235 poster, or over any radio or television station, or in any other way, an  
236 advertisement, announcement or statement containing any assertion,  
237 representation or statement with respect to the business of insurance  
238 or with respect to any person in the conduct of his insurance business,  
239 which is untrue, deceptive or misleading.

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

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

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

264 report or statement of such insurer.

265 (6) Unfair claim settlement practices. Committing or performing  
266 with such frequency as to indicate a general business practice any of  
267 the following: [(a)] (A) Misrepresenting pertinent facts or insurance  
268 policy provisions relating to coverages at issue; [(b)] (B) failing to  
269 acknowledge and act with reasonable promptness upon  
270 communications with respect to claims arising under insurance  
271 policies; [(c)] (C) failing to adopt and implement reasonable standards  
272 for the prompt investigation of claims arising under insurance policies;  
273 [(d)] (D) refusing to pay claims without conducting a reasonable  
274 investigation based upon all available information; [(e)] (E) failing to  
275 affirm or deny coverage of claims within a reasonable time after proof  
276 of loss statements have been completed; [(f)] (F) not attempting in  
277 good faith to effectuate prompt, fair and equitable settlements of  
278 claims in which liability has become reasonably clear; [(g)] (G)  
279 compelling insureds to institute litigation to recover amounts due  
280 under an insurance policy by offering substantially less than the  
281 amounts ultimately recovered in actions brought by such insureds;  
282 [(h)] (H) attempting to settle a claim for less than the amount to which  
283 a reasonable man would have believed he was entitled by reference to  
284 written or printed advertising material accompanying or made part of  
285 an application; [(i)] (I) attempting to settle claims on the basis of an  
286 application which was altered without notice to, or knowledge or  
287 consent of the insured; [(j)] (J) making claims payments to insureds or  
288 beneficiaries not accompanied by statements setting forth the coverage  
289 under which the payments are being made; [(k)] (K) making known to  
290 insureds or claimants a policy of appealing from arbitration awards in  
291 favor of insureds or claimants for the purpose of compelling them to  
292 accept settlements or compromises less than the amount awarded in  
293 arbitration; [(l)] (L) delaying the investigation or payment of claims by  
294 requiring an insured, claimant, or the physician of either to submit a  
295 preliminary claim report and then requiring the subsequent  
296 submission of formal proof of loss forms, both of which submissions  
297 contain substantially the same information; [(m)] (M) failing to

298 promptly settle claims, where liability has become reasonably clear,  
299 under one portion of the insurance policy coverage in order to  
300 influence settlements under other portions of the insurance policy  
301 coverage; [(n)] (N) failing to promptly provide a reasonable  
302 explanation of the basis in the insurance policy in relation to the facts  
303 or applicable law for denial of a claim or for the offer of a compromise  
304 settlement; [(o)] (O) using as a basis for cash settlement with a first  
305 party automobile insurance claimant an amount which is less than the  
306 amount which the insurer would pay if repairs were made unless such  
307 amount is agreed to by the insured or provided for by the insurance  
308 policy.

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

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

322 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447,  
323 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following  
324 practices shall be considered discrimination within the meaning of  
325 section 38a-446 or 38a-488 or a rebate within the meaning of section  
326 38a-825: [(a)] (A) Paying bonuses to policyholders or otherwise abating  
327 their premiums in whole or in part out of surplus accumulated from  
328 nonparticipating insurance, provided any such bonuses or abatement  
329 of premiums shall be fair and equitable to policyholders and for the  
330 best interests of the company and its policyholders; [(b)] (B) in the case

331 of policies issued on the industrial debit plan, making allowance to  
332 policyholders who have continuously for a specified period made  
333 premium payments directly to an office of the insurer in an amount  
334 which fairly represents the saving in collection expense; [(c)] (C)  
335 readjustment of the rate of premium for a group insurance policy  
336 based on loss or expense experience, or both, at the end of the first or  
337 any subsequent policy year, which may be made retroactive for such  
338 policy year.

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

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

365 of the mortgagee, vendor or lender, or is to the detriment of the  
366 borrower, mortgagor, purchaser, insurer or the producer complying  
367 with such a requirement. [(b)(i) Subsection (a)(iii)] (B)(i) Subparagraph  
368 (A)(iii) does not include the interest which may be charged on  
369 premium loans or premium advancements in accordance with the  
370 security instrument. (ii) For purposes of [subsection (a)(ii)]  
371 subparagraph (A)(ii), such disapproval shall be deemed unreasonable  
372 if it is not based solely on reasonable standards uniformly applied,  
373 relating to the extent of coverage required and the financial soundness  
374 and the services of an insurer. Such standards shall not discriminate  
375 against any particular type of insurer, nor shall such standards call for  
376 the disapproval of an insurance policy because such policy contains  
377 coverage in addition to that required. (iii) The commissioner may  
378 investigate the affairs of any person to whom this subsection applies to  
379 determine whether such person has violated this subsection. If a  
380 violation of this subsection is found, the person in violation shall be  
381 subject to the same procedures and penalties as are applicable to other  
382 provisions of section 38a-815, subsections (b) and (e) of section 38a-817  
383 and this section. (iv) For purposes of this section, "person" includes any  
384 individual, corporation, limited liability company, association,  
385 partnership or other legal entity.

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

392 (13) Refusing to insure, refusing to continue to insure or limiting the  
393 amount, extent or kind of coverage available to an individual or  
394 charging an individual a different rate for the same coverage solely  
395 because of blindness or partial blindness. For purposes of this  
396 subdivision, "refusal to insure" includes the denial by an insurer of  
397 disability insurance coverage on the grounds that the policy defines  
398 "disability" as being presumed in the event that the insured is blind or

399 partially blind, except that an insurer may exclude from coverage any  
400 disability, consisting solely of blindness or partial blindness, when  
401 such condition existed at the time the policy was issued. Any  
402 individual who is blind or partially blind shall be subject to the same  
403 standards of sound actuarial principles or actual or reasonably  
404 anticipated experience as are sighted persons with respect to all other  
405 conditions, including the underlying cause of the blindness or partial  
406 blindness.

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

411 (15) (A) Failure by an insurer, or any other entity responsible for  
412 providing payment to a health care provider pursuant to an insurance  
413 policy, to pay accident and health claims, including, but not limited to,  
414 claims for payment or reimbursement to health care providers, within  
415 the time periods set forth in subparagraph (B) of this subdivision,  
416 unless the Insurance Commissioner determines that a legitimate  
417 dispute exists as to coverage, liability or damages or that the claimant  
418 has fraudulently caused or contributed to the loss. Any insurer, or any  
419 other entity responsible for providing payment to a health care  
420 provider pursuant to an insurance policy, who fails to pay such a claim  
421 or request within the time periods set forth in subparagraph (B) of this  
422 subdivision shall pay the claimant or health care provider the amount  
423 of such claim plus interest at the rate of fifteen per cent per annum, in  
424 addition to any other penalties which may be imposed pursuant to  
425 sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60,  
426 inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to  
427 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155,  
428 inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-  
429 459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826,  
430 inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due  
431 a claimant or health care provider pursuant to this section is less than  
432 one dollar, the insurer shall deposit such amount in a separate interest-

433 bearing account in which all such amounts shall be deposited. At the  
434 end of each calendar year each such insurer shall donate such amount  
435 to The University of Connecticut Health Center.

436 (B) Each insurer, or other entity responsible for providing payment  
437 to a health care provider pursuant to an insurance policy subject to this  
438 section, shall pay claims not later than forty-five days after receipt by  
439 the insurer of the claimant's proof of loss form or the health care  
440 provider's request for payment filed in accordance with the insurer's  
441 practices or procedures, except that when there is a deficiency in the  
442 information needed for processing a claim, as determined in  
443 accordance with section 38a-477, the insurer shall (i) send written  
444 notice to the claimant or health care provider, as the case may be, of all  
445 alleged deficiencies in information needed for processing a claim not  
446 later than thirty days after the insurer receives a claim for payment or  
447 reimbursement under the contract, and (ii) pay claims for payment or  
448 reimbursement under the contract not later than thirty days after the  
449 insurer receives the information requested.

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

454 (16) Failure to pay, as part of any claim for a damaged motor vehicle  
455 under any automobile insurance policy where the vehicle has been  
456 declared to be a constructive total loss, an amount equal to the sum of  
457 (A) the settlement amount on such vehicle plus, whenever the insurer  
458 takes title to such vehicle, (B) an amount determined by multiplying  
459 such settlement amount by a percentage equivalent to the current sales  
460 tax rate established in section 12-408. For purposes of this subdivision,  
461 "constructive total loss" means the cost to repair or salvage damaged  
462 property, or the cost to both repair and salvage such property, equals  
463 or exceeds the total value of the property at the time of the loss.

464 (17) Any violation of section 42-260, by an extended warranty

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

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

483 (19) With respect to an insurance company, hospital service  
484 corporation, health care center or fraternal benefit society providing  
485 individual or group health insurance coverage of the types specified in  
486 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-  
487 469, refusing to insure, refusing to continue to insure or limiting the  
488 amount, extent or kind of coverage available to an individual or  
489 charging an individual a different rate for the same coverage because  
490 of genetic information. Genetic information indicating a predisposition  
491 to a disease or condition shall not be deemed a preexisting condition in  
492 the absence of a diagnosis of such disease or condition that is based on  
493 other medical information. An insurance company, hospital service  
494 corporation, health care center or fraternal benefit society providing  
495 individual health coverage of the types specified in subdivisions (1),  
496 (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be  
497 prohibited from refusing to insure or applying a preexisting condition  
498 limitation, to the extent permitted by law, to an individual who has

499 been diagnosed with a disease or condition based on medical  
500 information other than genetic information and has exhibited  
501 symptoms of such disease or condition. For the purposes of this  
502 subsection, "genetic information" means the information about genes,  
503 gene products or inherited characteristics that may derive from an  
504 individual or family member.

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

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

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

510 (23) Each insurer or other entity responsible for providing payment  
511 to a managed residential community or assisted living services agency  
512 pursuant to an assignment of benefits, as defined in section 19a-693, as  
513 amended by this act, shall pay benefits due under a long-term care  
514 policy not later than forty-five days after receipt by the insurer of an  
515 assignment of benefits election form executed in accordance with  
516 subsection (c) of section 19a-694, as amended by this act, or subsection  
517 (c) of section 19a-699, as amended by this act, and a request by the  
518 managed residential community or assisted living services agency for  
519 payment filed in accordance with the insurer's practices or procedures,  
520 except that when there is a deficiency in the information needed for  
521 processing a claim, as determined in accordance with section 38a-501,  
522 as amended by this act, the insurer shall (A) send written notice to the  
523 managed residential community or assisted living services agency, as  
524 the case may be, of all alleged deficiencies in information needed for  
525 processing a claim not later than thirty days after the insurer receives a  
526 claim for payment or reimbursement under the contract, and (B) pay  
527 claims for payment or reimbursement under the contract not later than  
528 thirty days after the insurer receives the information requested."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2009</i>	19a-693
Sec. 2	<i>July 1, 2009</i>	19a-694
Sec. 3	<i>July 1, 2009</i>	19a-700
Sec. 4	<i>July 1, 2009</i>	19a-699
Sec. 5	<i>July 1, 2009</i>	38a-501(a)
Sec. 6	<i>July 1, 2009</i>	38a-816