
OLR Bill Analysis

SB 920

AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.

SUMMARY:

This bill makes changes in various insurance statutes. It:

1. expands the list of regulated entities for which the insurance commissioner may hire financial examination consultants (at the entity's expense) to include any entity that must be licensed by, or registered with, the Insurance Department (§§ 1 and 6);
2. increases the filing fee for arbitrating disputes between auto insurers and claimants concerning certain private passenger auto insurance claims from \$20 for both to \$100 for an insurer and \$50 for a claimant (§ 2);
3. amends the statutory description of the Insurance Department to remove obsolete references (§ 2);
4. establishes a \$2,500 fee for filing Form A (i.e., the legally required statement about acquiring control of a Connecticut insurer) (§ 3);
5. authorizes the commissioner to (a) order a health care center (i.e., HMO) to produce books, records, and other information it or an affiliate has and the department needs to examine the company, a power he has with respect to insurers, and (b) examine an HMO's affiliate if the HMO fails to comply with the order (§ 4);
6. requires an HMO to pay costs related to the department's examination of it, including costs to hire consultants to assist with the examination (§ 4);

7. revises the market conduct examination law with respect to costs, immunity, and confidentiality (see below) (§ 5);
8. allows the commissioner to disclose an examination report of a captive insurance company to any state agency in Connecticut or elsewhere if the agency agrees in writing to keep it confidential (§ 7);
9. imposes the same tax assessment, collection, payment, and annual return requirements and procedures on captive insurers that apply to all other insurance companies and requires them to pay taxes by March 1 annually, instead of in February (§ 8);
10. specifies that the department regulates insurance covering bank deposits in excess of the Federal Deposit Insurance Corporation as a surety bond product rather than a financial guaranty (§ 9);
11. applies the external appeal statute to single service ancillary health coverage plans, including dental, vision, and prescription drug plans (§ 11); and
12. applies the health insurance claim prompt payment requirements (see BACKGROUND) to health care providers licensed in another state, in addition to the Connecticut-licensed providers currently covered, to conform to Attorney General Opinion 2008-15 (§ 15).

The bill removes obsolete references in the Medicare supplement laws (§§ 12-14) and makes other technical and conforming changes.

EFFECTIVE DATE: October 1, 2011, except for the increased arbitration fee, revised department organizational description, captive insurer, bank deposit, and external appeal provisions, which are effective on passage. The captive insurer tax provision is applicable to calendar years beginning on or after January 1, 2011.

§ 5 – MARKET CONDUCT EXAMINATIONS

A market conduct examination is an Insurance Department's audit

of a company licensed to do business in Connecticut to determine compliance with applicable state laws and regulations. It is separate and distinct from a financial examination, but may be conducted at the same time.

Costs

By law, the company being examined must pay examination costs. The bill specifies that these include the department's cost to hire consultants to assist with the examination.

The bill exempts a Connecticut company under examination from paying the salaries, fringe benefits, travel, and maintenance expenses of the department's examining personnel if the company is assessed under law to pay the Insurance Department's operating expenses.

By law, unchanged by the bill, a Connecticut company under examination must pay the examiner's travel and maintenance expenses when the department examines the company outside of Connecticut.

Immunity

The bill specifies that no cause of action or liability accrues against certain activities of specified people for activities performed in good faith.

Specifically, no cause of action or liability accrues against the commissioner, his authorized representatives, or appointed examiners for statements made or conduct performed in good faith while carrying out market conduct action. And no cause of action or liability accrues against anyone communicating or delivering information to the commissioner, his representative, or examiner during an examination if the communication or delivery is performed in good faith and without the intent to defraud or deceive.

If someone files a civil action for libel, slander, or any other relevant tort arising out of examination activities against the commissioner, his authorized representative, or an appointed examiner, the bill entitles the commissioner or other person to an award of attorney's fees and costs if (1) he or she prevails and (2) the party bringing the action was

not substantially justified in doing so. The bill defines a proceeding as “substantially justified” if it had a reasonable basis in law or fact when it was initiated.

The bill states that it does not abrogate or modify any common law or statutory privilege or immunity the people mentioned above currently enjoy.

Confidentiality

The bill makes working papers, recorded information, documents, and copies of these, produced or obtained by, or disclosed to, the commissioner or anyone during a market conduct examination confidential and not subject to subpoena. The bill prohibits the commissioner or anyone else from making them public, except the commissioner may grant the National Association of Insurance Commissioners access, if it agrees in writing to keep them confidential.

The bill also authorizes the commissioner to share an examination report, preliminary report or results, or any related matter with other state or federal agencies, international regulatory agencies, and law enforcement authorities, if the recipient agrees in writing to keep the report or matters confidential.

BACKGROUND

Prompt Claim Payment Requirements

By law, an insurer or other entity responsible for paying health and accident claims must pay a clean claim, including those payable to a health care provider, within 45 days of receiving it (CGS § 38a-816(15)). A claim is considered “clean” if it is submitted with all information required by law (CGS § 38a-477).

If a claim contains a deficiency, the entity must send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies within 30 days of receiving the claim. The entity must process the claim within 30 days of receiving the corrected claim. The entity must add 15% interest if payment is late.

The prompt pay law defines “health care provider” as a physician,

surgeon, chiropractor, natureopath, podiatrist, athletic trainer, physical therapist, occupational therapist, alcohol and drug counselor, radiologist, midwife, nurse, nurse's aide, dentist, dental hygienist, optometrist, optician, respiratory care practitioner, perfusionist, pharmacist, psychologist, marital and family therapist, clinical social worker, professional counselor, massage therapist, dietician-nutritionist, acupuncturist, emergency medical service technician (EMT), and licensed health care institution.

Licensed health care institution includes a hospital; residential care home; health care facility for the handicapped; nursing home; rest home; home health care agency; homemaker-home health aide agency; mental health facility; substance abuse treatment facility; student infirmary; an EMT organization; a facility providing services for the prevention, diagnosis, and treatment of human health conditions; and a Medicaid-certified residential facility for the mentally retarded.

Related Bills

sSB 16, reported by the Insurance and Real Estate Committee, changes the prompt claim payment requirements. Instead of requiring claims to be paid within 45 days, it requires paper claims to be paid within 60 days and electronic claims within 15 days.

SB 849 (File 13), reported by the Insurance and Real Estate Committee, makes different technical changes to the Medicare supplement laws.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 2 (03/15/2011)