



Senate

General Assembly

File No. 274

January Session, 2013

Substitute Senate Bill No. 1031

Senate, April 2, 2013

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT CONCERNING THE INSURANCE DEPARTMENT'S
AUTHORITY TO PROTECT CONSUMERS.***

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

1 Section 1. Section 38a-436 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2014*):

3 (a) Every individual life insurance policy delivered or issued for
4 delivery to any person in this state shall have printed thereon or
5 attached thereto a notice stating, in substance, that the policy may be
6 returned by the applicant for cancellation by delivering or mailing the
7 policy to the insurer or to the insurance agent through whom it was
8 effected, at any time within ten days after receipt of the policy by the
9 applicant, and that upon the delivery or mailing the policy shall be
10 void ab initio.

11 (b) The insurer shall maintain proof of the date and manner of its
12 delivery or mailing of the policy and notice for a period of seven years
13 after such delivery or mailing. The insurer may maintain such proof in

14 paper, photographic, mechanical, magnetic or electronic media or in
15 any other form or media or by any other process that accurately
16 demonstrates the date of such delivery or mailing, and shall make such
17 proof available to the commissioner upon request.

18 Sec. 2. Section 38a-702k of the general statutes is repealed and the
19 following is substituted in lieu thereof (*Effective January 1, 2014*):

20 (a) The commissioner may place on probation, suspend, revoke or
21 refuse to issue or renew an insurance producer's license or may levy a
22 civil penalty in accordance with the provisions of this title, or may take
23 any combination of such actions, for any one or more of the following
24 causes: (1) Providing incorrect, misleading, incomplete or materially
25 untrue information in the license application; (2) violating any
26 insurance laws, or violating any regulation, subpoena or order of the
27 commissioner or of another state's commissioner; (3) obtaining or
28 attempting to obtain a license through misrepresentation or fraud; (4)
29 improperly withholding, misappropriating or converting any moneys
30 or properties received in the course of doing an insurance business; (5)
31 intentionally misrepresenting the terms of an actual or proposed
32 insurance contract or application for insurance; (6) having been
33 convicted of a felony; (7) having admitted or been found to have
34 committed any insurance unfair trade practice or fraud; (8) using
35 fraudulent, coercive or dishonest practices, or demonstrating
36 incompetence, untrustworthiness or financial irresponsibility in the
37 conduct of business in this state or elsewhere; (9) having an insurance
38 producer license, or its equivalent, denied, suspended or revoked in
39 any other state, province, district or territory; (10) forging another's
40 name to an application for insurance or to any document related to an
41 insurance transaction; (11) improperly using notes or any other
42 reference material to complete an examination for an insurance license;
43 (12) knowingly accepting insurance business from an individual who
44 is not licensed; (13) failing to comply with an administrative or court
45 order imposing a child support obligation; or (14) failing to pay state
46 income tax or comply with any administrative or court order directing
47 payment of state income tax.

48 (b) If the action by the commissioner is to nonrenew a license or to
49 deny an application for a license, the commissioner shall notify the
50 applicant or licensee and advise, in writing, the applicant or licensee of
51 the reason for the denial or nonrenewal of the applicant's or licensee's
52 license. The applicant or licensee may make written demand upon the
53 commissioner, not later than thirty days after the notice, for a hearing
54 before the commissioner to determine the reasonableness of the
55 commissioner's action. The hearing shall be held not later than twenty
56 days after receipt of such request and shall be held pursuant to section
57 38a-19.

58 (c) The license of a business entity may be suspended, revoked or
59 refused if the commissioner finds, after hearing, that an individual
60 licensee's violation was known or should have been known by one or
61 more of the partners, officers or managers acting on behalf of the
62 partnership or corporation and the violation was neither reported to
63 the commissioner nor corrective action taken.

64 (d) In addition to or in lieu of any applicable denial, suspension or
65 revocation of a license, a person may, after hearing, be subject to a civil
66 fine pursuant to section 38a-774.

67 (e) In addition to any other penalty imposed on a licensee under this
68 section, the commissioner may order such licensee to pay restitution or
69 the amount of any uninsured claim or loss if the commissioner finds,
70 after hearing, that such licensee has committed a violation described in
71 subdivision (4), (7) or (8) of subsection (a) of this section.

72 [(e)] (f) The commissioner shall retain the authority to enforce the
73 provisions of, and impose any penalty or remedy authorized by, this
74 title against any person who is under investigation for or charged with
75 a violation of this title even if the person's license or registration has
76 been surrendered or has lapsed by operation of law.

77 Sec. 3. Subdivision (15) of section 38a-816 of the general statutes is
78 repealed and the following is substituted in lieu thereof (*Effective*
79 *January 1, 2014*):

80 (15) (A) Failure by an insurer, or any other entity responsible for
81 providing payment to a claimant or health care provider pursuant to
82 an insurance policy, to pay accident and health claims, including, but
83 not limited to, claims for payment or reimbursement to claimants or
84 health care providers, within the time periods set forth in
85 subparagraph (B) of this subdivision, unless the Insurance
86 Commissioner determines that a legitimate dispute exists as to
87 coverage, liability or damages or that the claimant has fraudulently
88 caused or contributed to the loss. Any insurer, or any other entity
89 responsible for providing payment to a claimant or health care
90 provider pursuant to an insurance policy, [who] that fails to pay such a
91 claim or request within the time periods set forth in subparagraph (B)
92 of this subdivision shall pay the claimant or health care provider the
93 amount of such claim plus interest at the rate of fifteen per cent per
94 annum, in addition to any other penalties [which] that may be
95 imposed pursuant to sections 38a-11, 38a-25, 38a-41 to 38a-53,
96 inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-
97 76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140,
98 inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290,
99 inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
100 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
101 inclusive. Whenever the interest due a claimant or health care provider
102 pursuant to this section is less than one dollar, the insurer shall deposit
103 such amount in a separate interest-bearing account in which all such
104 amounts shall be deposited. At the end of each calendar year each such
105 insurer shall donate such amount to The University of Connecticut
106 Health Center.

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

110 (i) For claims filed in paper format, sixty days after receipt by the
111 insurer of the claimant's proof of loss form or the health care provider's
112 request for payment filed in accordance with the insurer's practices or
113 procedures, except that when there is a deficiency in the information

114 needed for processing a claim submitted by a health care provider, as
115 determined in accordance with section 38a-477, or a deficiency in the
116 information submitted by a claimant in accordance with the insurer's
117 practices and procedures as reasonably applied to the claimant, the
118 insurer shall (I) send written notice to the claimant or health care
119 provider, as the case may be, of all alleged deficiencies in information
120 needed for processing a claim not later than thirty days after the
121 insurer receives a claim for payment or reimbursement under the
122 contract, and (II) pay claims for payment or reimbursement under the
123 contract not later than thirty days after the insurer receives the
124 information requested; and

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

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

143 Sec. 4. (NEW) (*Effective January 1, 2014*) No insurer, health care
144 center, fraternal benefit society, hospital service corporation, medical
145 service corporation or other entity delivering, issuing for delivery,
146 renewing, amending or continuing any individual or group health

147 insurance policy or health care plan in this state shall offer, deliver or
148 issue for delivery any such policy or plan that (1) includes any
149 provision that reserves discretion to such insurer, health care center,
150 fraternal benefit society, hospital service corporation, medical service
151 corporation or other entity to interpret the terms of such policy or plan,
152 or (2) provides standards of interpretation or review that are
153 inconsistent with the laws of this state.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2014</i>	38a-436
Sec. 2	<i>January 1, 2014</i>	38a-702k
Sec. 3	<i>January 1, 2014</i>	38a-816(15)
Sec. 4	<i>January 1, 2014</i>	New section

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note**State Impact:** None**Municipal Impact:** None**Explanation**

This bill allows the Insurance Commissioner to require an insurance producer to pay restitution in certain circumstances. It also prohibits certain provisions in health insurance policies. As these provisions concern insurance transactions between private entities, there is no fiscal impact.

The Out Years**State Impact:** None**Municipal Impact:** None

OLR Bill Analysis

sSB 1031

***AN ACT CONCERNING THE INSURANCE DEPARTMENT'S
AUTHORITY TO PROTECT CONSUMERS.***

SUMMARY:

This bill allows the insurance commissioner to order a licensed insurance producer (e.g., a salesperson) to pay restitution or the amount of an uninsured claim or loss if he finds that the producer has engaged in specified behavior.

It bars insurance companies and other insurers from issuing for delivery, renewing, amending, or continuing an individual or group health insurance policy or health care plan in the state that (1) includes any provision that gives the insurer discretion to interpret the policy's or plan's terms or (2) provides interpretation or review standards that are inconsistent with state law.

By law, individual life insurance policies delivered or issued for delivery in the state must include a notice stating that the applicant can cancel the policy by delivering or mailing it to the insurer or insurance agent who sold it, at any time within 10 days after receiving it. The bill requires that the insurer maintain proof of the date and how the policy and notice were delivered or mailed for seven years after the delivery or mailing. The insurer may maintain this proof in paper, photographic, mechanical, magnetic, or electronic media, or in any other form or media or by any other process that accurately demonstrates the date of the delivery or mailing. The insurer must make this proof available to the commissioner upon request.

The bill makes minor changes regarding the deadlines for insurers to pay claims and the penalties for failing to do so.

EFFECTIVE DATE: January 1, 2014

RESTITUTION

The bill allows the commissioner to order a licensed insurance producer to pay restitution or the amount of an uninsured claim or loss if he finds that the producer has:

1. improperly withheld, misappropriated, or converted any money or property received in the course of doing an insurance business;
2. admitted to or been found to have committed any insurance unfair trade practice or fraud; and
3. used fraudulent, coercive, or dishonest practices, or demonstrated incompetence, untrustworthiness or financial irresponsibility in the conduct of business in Connecticut or elsewhere.

The commissioner must hold a hearing before imposing these penalties, which are in addition to penalties he can impose by law.

FAILING TO PAY CLAIMS ON TIME

The bill makes it clear that the same (1) deadlines apply for an insurer to pay a claim made by a claimant (e.g., a policyholder) as one made by a health care provider and (2) penalties apply for failing to do so for both types of claims.

By law, insurers generally must pay paper claims filed in accordance with their practices or procedures within 60 days and pay electronically-filed claims within 20 days. However, if there is a deficiency in the information a health care provider submits on a standardized claim form, the insurer must (1) inform the provider of the alleged deficiencies within 30 days of receiving a paper claim and 10 days of receiving an electronic claim and (2) pay the claim once the insurer receives the requested information, again within 30 days for paper claims and 10 days for electronic claims. The bill extends these

provisions when there is a deficiency in the information a claimant submits in accordance with the insurer's practices and procedures as reasonably applied to the claimant.

The bill makes it clear that the failure of an insurer or other entity responsible for paying claims to comply with these deadlines with regard to claims made by claimants is an unfair insurance practice. By law, both claimants and health care providers are entitled to 15% annual interest on the unpaid claim and the insurance commissioner can impose other penalties.

By law, the deadlines do not apply if the Insurance Department determines that (1) there is a legitimate dispute about coverage, liability, or damages or (2) the claimant has fraudulently caused or contributed to the loss.

BACKGROUND

Connecticut Unfair Insurance Practice Act (CUIPA)

CUIPA prohibits engaging in unfair or deceptive insurance acts or practices. It authorizes the insurance commissioner to issue regulations, conduct investigations and hearings, issue cease and desist orders, ask the attorney general to seek injunctive relief in Superior Court, impose fines, revoke or suspend licenses, and order restitution.

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

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 12 Nay 6 (03/14/2013)