File No. 479

(Reprint of File No. 142)

House Bill No. 5616
As Amended by House
Amendment Schedules
"A" and "B"

Approved by the Legislative Commissioner
April 9, 1998

AN ACT MAKING TECHNICAL CORRECTIONS TO THE INSURANCE AND REAL ESTATE LAWS AND AMENDING CERTAIN FILING DEADLINES FOR MANAGED CARE ORGANIZATIONS.

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

Section 1. Section 20-325f of the general statutes is repealed and the following is substituted in lieu thereof:

No real estate broker shall make any unilateral offer of subagency or agree to compensate, appoint, employ, cooperate with or otherwise affiliate with a subagent for the sale or purchase of real property without the informed written consent of the person [for] whom the real estate broker represents. Such written consent shall contain the name and real estate license number of the real estate broker to be appointed as the subagent and shall contain a statement notifying the person [for] whom the real estate broker represents that the law imposes vicarious liability on the principal for the acts of the subagent.

Sec. 2. Subsection (a) of section 20-325h of the general statutes is repealed and the following is substituted in lieu thereof:

(a) After the termination of an agency relationship between a real estate licensee and a person [for] whom the real estate licensee represented, no real estate licensee shall: (1) Reveal confidential information concerning that person; (2) use confidential information concerning that person to the person's disadvantage; or (3) use confidential information concerning that person for the real estate broker's or real estate salesperson's advantage or the advantage of a third party, except as required by legal process, as necessary to defend the real estate broker or real estate salesperson from allegations of wrongful or negligent conduct, or as necessary to prevent the commission of a crime.

Sec. 3. Section 20-325g of the general statutes is repealed and the following is substituted in lieu thereof:

There shall be a conclusive presumption that a person has given [his] informed consent to a dual agency relationship with a real estate broker if that person executes a written consent in the following form prior to executing any contract or agreement for the purchase, sale or lease of real estate:

DUAL AGENCY CONSENT AGREEMENT

Property Address: ....
Seller(s) or Landlord(s): ....
Buyer(s) or Tenant(s): ....

(1) This Dual Agency Consent Agreement is an addendum to and make part of (check all that apply):

( ) Listing Agreement dated .... between brokerage firm and seller or landlord.

( ) Buyer [on] OR tenant agency agreement dated .... between brokerage firm and buyer or tenant.

(2) Seller and buyer (or landlord and tenant, as the case may be) hereby acknowledge and agree that .... (name of brokerage firm) is representing both buyer and seller (or landlord and tenant, as

the case may be) in the purchase and sale (or lease) of the above referenced property and that brokerage firm has been and is now the agent of both seller and buyer (or landlord and tenant, as the case may be). Seller and buyer (or landlord and tenant, as the case may be) have both consented to and hereby confirm their consent to this dual representation.

(3) Seller and buyer (or landlord and tenant, as the case may be) agree: (A) The brokerage firm shall not be required to and shall not disclose to either buyer or seller (or landlord or tenant, as the case may be) any personal, financial or other confidential information to such other party without the express written consent of the party whose information is disclosed, other than information related to material property defects which are known to the brokerage firm and other information the brokerage firm is required to disclose by law. (B) The brokerage firm may not disclose: (i) To the buyer that the seller (landlord) will accept less than the asking or listed price, unless otherwise instructed to do so in writing by the seller (landlord); (ii) to the seller (landlord) that the buyer (tenant) can or will pay a price greater than the price submitted in a written offer to the seller (landlord), unless otherwise instructed to do so in writing by the buyer (tenant); (iii) the motivation of the seller or buyer (or landlord or tenant, as the case may be) for selling, buying or leasing property, unless otherwise instructed in writing by the respective party; or (iv) that a seller or buyer will agree to financing terms other than those offered, unless instructed in writing by the respective party.

(4) Property information available through the multiple listing service or otherwise, including listed and sold properties, which has been requested by either the seller or the buyer (or landlord or tenant, as the case may be) shall be disclosed to both seller and buyer (or landlord and tenant, as the case may be).

(5) Both parties are advised to seek competent legal and tax advice with regard to this transaction, and with regard to all documents executed in connection with this transaction, including this Dual Agency Consent Agreement.

I have read and understand the above agreement

Buyer (Landlord)	Seller (Tenant)	Brokerage Firm
....	....	....
		(Authorized Representative)
....	....	....
		(Company Name)
....	....	....
Date	Date	Date

Sec. 4. Section 38a-887 of the general statutes is repealed and the following is substituted in lieu thereof:

When the commissioner has caused to be paid from [such] THE BROKERED TRANSACTIONS guaranty fund any sum to the aggrieved person, the department shall be subrogated to all of the rights of the aggrieved person up to the amount paid, and the aggrieved person shall assign all of his right, title and interest in the claim. By accepting payment from the guaranty fund the aggrieved person shall agree to cooperate with the department in any action it takes against the licensed insurance producer or unlicensed person acting as a producer engaged in the business of insurance. Any amount and interest recovered by the department shall be deposited to [such] SAID guaranty fund.

Sec. 5. Subsection (a) of section 38a-884 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Any person aggrieved under section 38a-880 may apply to the Insurance Department for an order directing payment out of [such] THE BROKERED TRANSACTIONS guaranty fund subject to the limitations stated in said section and the limitations specified in this section.

Sec. 6. Subsection (d) of section 38a-884 of the general statutes is repealed and the following is substituted in lieu thereof:

(d) The payment from [such] SAID fund of any amount in settlement of a claim against a licensed insurance producer or an unlicensed person acting as a producer engaged in the business of insurance pursuant to an order under subsection (c), shall constitute cause for the suspension or revocation of any license issued by the commissioner or for

the imposition of a fine pursuant to section 38a-774 and for an order of restitution to the fund in the amount it has paid, and such producer or unlicensed person shall not be eligible to apply for a license until he has repaid in full, plus interest at a rate to be determined by the department and which shall reflect current market rates, the amount paid from [such] SAID guaranty fund on his account. A discharge in bankruptcy shall not relieve a person from the penalties and disabilities provided in this subsection.

Sec. 7. Subsection (e) of section 38a-884 of the general statutes is repealed and the following is substituted in lieu thereof:

(e) If, at any time, the money deposited in such guaranty fund is insufficient to satisfy any duly authorized claim or portion thereof, the department shall, when sufficient money has been deposited in [such] SAID guaranty fund, satisfy such unpaid claims or portions thereof, in the order that such claims or portions thereof were originally filed, plus accumulated interest at the rate of four per cent a year.

Sec. 8. Section 38a-883 of the general statutes is repealed and the following is substituted in lieu thereof:

No application to recover compensation under sections 38a-880 to 38a-889, inclusive, which might subsequently result in an order for collection from [such] THE BROKERED TRANSACTIONS guaranty fund shall be brought later than two years from the action of an insurance producer duly licensed in this state under section 38a-769, or an unlicensed person acting as a producer engaged in the business of insurance, by reason of the embezzlement of money or property, or the unlawful obtainment of money or property from any person by false pretenses, artifice, trickery or forgery, or by reason of any fraud, misrepresentation or deceit by or on the part of any such producer or unlicensed person acting as a producer engaged in the business of insurance, excluding the failure in performance of contractual obligations due to the impairment of an insurer.

Sec. 9. Subsection (b) of section 38a-882 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) If, at any time, the amount deposited in the Brokered Transactions Guaranty Fund is under one hundred thousand dollars, the department, in its discretion, may assess all persons licensed as insurance producers a fee not to exceed ten dollars which shall be credited to [such] SAID guaranty fund.

Sec. 10. Subdivision (8) of section 38a-816 of the general statutes, as amended by public act 97-95, is repealed and the following is substituted in lieu thereof:

(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 [insurers] INSURER, producer or individual.

Sec. 11. Subdivision (11) of section 38a-816 of the general statutes, as amended by public act 97-95, is repealed and the following is substituted in lieu thereof:

(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; or (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; (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) Subsection (a) (iii) does not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of subsection (a) (ii), 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 subsection applies to determine whether such person has violated this subsection. If a violation of this subsection 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.

Sec. 12. Section 38a-226d of the general statutes, as amended by section 19 of public act 97-99, is repealed and the following is substituted in lieu thereof:

The commissioner may find that the standards in section 38a-226c, AS AMENDED, have been met if each utilization review company has received approval or accreditation by a utilization review accreditation organization, or otherwise demonstrates to the commissioner that it adheres to standards which are substantially similar to the standards in said section 38a-226c, AS AMENDED, provided such approval, accreditation or standards [does] DO not provide less protection to enrollees than is provided under said section 38a-226c, AS AMENDED.

Sec. 13. Section 8 of public act 97-202 is repealed and the following is substituted in lieu thereof:

Each viatical settlement provider and viatical settlement broker shall disclose in

writing the following information to each viator prior to the date all parties execute a viatical settlement contract:

(1) The possible alternatives to, or options that may be exercised in conjunction with, the viatical settlement contract, including, but not limited to, accelerated death benefits offered by the insurer of such viator's life insurance policy or group life insurance policy to which the viator's certificate relates;

(2) [Some] THAT SOME or all of the proceeds of the viatical settlement may be free from federal income tax or from state tax, and shall advise parties to seek assistance from a professional tax advisor;

(3) [Receipt] THAT RECEIPT of the viatical settlement proceeds may adversely affect the viator's eligibility for Medicaid or other government benefits, and advice should be obtained from the appropriate governmental agencies or advisors;

(4) [The] THAT THE viatical settlement provider may assign or otherwise transfer its interests in the viaticated policy to a third party;

(5) [The] THAT THE viator may rescind the viatical settlement contract within fifteen days after the viator's receipt of the viatical settlement proceeds; and

(6) [The fact that] THAT the viatical settlement proceeds may be subject to the claims of creditors.

Sec. 14. Subsection (d) of section 38a-476 of the general statutes, as amended by section 65 of public act 97-8 of the June 18 special session, is repealed and the following is substituted in lieu thereof:

(d) With respect to a newly insured individual who was previously covered under qualifying coverage, but who was not covered under such qualifying coverage for a preexisting condition, as defined under the new health insurance plan or arrangement, such plan or arrangement shall credit the time such [person] INDIVIDUAL was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding coverage was continuous to a date less than sixty-three days prior to the

effective date of the new coverage, exclusive of any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than ninety days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within sixty-three days of [their] SUCH INDIVIDUAL'S initial eligibility.

Sec. 15. Subsection (a) of section 21 of public act 97-99 is repealed and the following is substituted in lieu thereof:

(a) Each managed care organization shall conform to all applicable state and federal antidiscrimination and confidentiality statutes, shall ensure that the confidentiality of specified enrollee patient information and records in [their] ITS custody is protected, and shall have written confidentiality policies and procedures.

Sec. 16. Subsection (e) of section 38a-497a of the general statutes, as amended by section 15 of public act 97-7 of the June 18 special session, is repealed and the following is substituted in lieu thereof:

(e) If a parent is required by a court or an administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the state, such employer shall permit such parent to enroll such child under such coverage without regard to any open enrolment restrictions. If a parent is enrolled but fails to make application to obtain coverage of a child, the employer shall enroll such child under health care coverage upon application by the child's other parent or by the Commissioner of Social Services, or his designee, when such child is eligible under the Medicaid program or is receiving child support enforcement services pursuant to Title IV-D of the Social Security Act. If a noncustodial parent in a IV-D case provides such coverage and changes employment, and the new employer provides health care coverage, the IV-D agency or an agency under cooperative agreement therewith shall transfer notice of the provision for health care coverage

to such new employer. The notice shall operate to enroll the child in the noncustodial parent's health care plan if that portion of the obligor's income which is subject to withholding pursuant to subsection (e) of section 52-362, AS AMENDED, is sufficient to cover both the support order and health care coverage. At the time notice is transferred to the employer, the IV-D agency, or an agency under cooperative agreement therewith, shall also cause a copy of the notice of such transfer of health care coverage to be delivered to the obligor and to the custodial parent. The noncustodial parent may contest such notice by filing a motion for modification with the family support magistrate. An employer, subject to the provisions of this section, shall not disenroll or eliminate coverage of any such child unless the employer is provided satisfactory written evidence that: (1) A court or an administrative order for health care coverage is no longer in effect; (2) the child is or shall be enrolled in comparable health care coverage which shall take effect not later than the effective date of such disenrolment or elimination; or (3) the employer has eliminated family health care coverage for all of its employees.

Sec. 17. Subsection (a) of section 38a-504 of the general statutes, as amended by section 3 of public act 97-198, is repealed and the following is substituted in lieu thereof:

(a) Any insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society which delivers or issues for delivery in this state individual health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), [(6),] (10), (11) and (12) of section 38a-469, shall provide coverage under such policies for the surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, and outpatient chemotherapy following surgical procedure in connection with the treatment of tumors. Such benefits shall be

subject to the same terms and conditions applicable to all other benefits under such policies.

Sec. 18. Subdivision (1) of section 38a-846 of the general statutes, as amended by section 6 of public act 97-125, is repealed and the following is substituted in lieu thereof:

(1) The board of directors, upon majority vote, shall notify the commissioner of any information which [they] IT may have indicating any member insurer may be insolvent or in a financial condition hazardous to its policyholders or the public.

Sec. 19. Subsection (a) of section 4 of public act 97-99 is repealed and the following is substituted in lieu thereof:

(a) On or before May 1, 1998, and annually thereafter, each managed care organization shall submit to the commissioner:

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of managed care organization's utilization review determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) NOTWITHSTANDING THE PROVISIONS OF THIS SUBSECTION, ON OR BEFORE JULY 1, 1998, AND ANNUALLY THEREAFTER, all data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). If an organization does not provide information for the National

Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54 of the general statutes. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision.

(2) A model contract that contains the provisions currently in force in contracts between the organization and participating providers in this state and, upon the commissioner's request, a copy of any individual contracts between such parties, provided the contract may withhold or redact proprietary fee schedule information.

(3) A written statement of the types of financial arrangements or contractual provisions that the managed care organization has with hospitals, utilization review companies, physicians and any other health care providers including, but not limited to, compensation based on a fee-for-service arrangement, a risk-sharing arrangement or a capitated risk arrangement.

(4) Such information as the commissioner deems necessary to complete the consumer report card he is required to develop and distribute pursuant to section 13 of [this act] PUBLIC ACT 97-99, AS AMENDED. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this section, including any change in a plan's rates over the prior three years, its medical loss ratio or percentage of the total premium revenues spent on medical care compared to administrative costs and plan marketing, how it compensates health care providers and its premium level; (C) a description of services, the number of primary care physicians

and specialists, and distribution and the number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and speciality care provider, the percentage of primary and speciality care providers who are board certified, and how the medical protocols incorporate input as required in section 6 of [this act] PUBLIC ACT 97-99, AS AMENDED; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner.

(5) A summary of the procedures used by managed care organizations to credential providers.

* * * * *

"THE FOLLOWING FISCAL IMPACT STATEMENT AND BILL ANALYSIS ARE PREPARED FOR THE BENEFIT OF 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 HOUSE THEREOF FOR ANY PURPOSE."

* * * * *

FISCAL IMPACT STATEMENT - BILL NUMBER HB 5616

STATE IMPACT	None, see explanation below
MUNICIPAL IMPACT	None
STATE AGENCY(S)	Department of Insurance

EXPLANATION OF ESTIMATES:

The bill makes several minor technical corrections to the insurance and real estate statutes. It has no impact on the workload of the Department of Insurance.

House "A" is technical in nature and has no fiscal impact.

House "B" is technical in nature and has no fiscal impact.

* * * * *

OLR AMENDED BILL ANALYSIS

HB 5616 (as amended by House "A" and "B")*

AN ACT MAKING TECHNICAL CORRECTIONS TO THE INSURANCE AND REAL ESTATE LAWS

SUMMARY: This bill extends by two months the filing deadline for managed care organizations (MCOs) to submit to the insurance commissioner data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). It requires MCOs to file this data by July 1, 1998 and annually thereafter instead of May 1, 1998 and annually thereafter.

The bill also makes several gender-neutral language changes and minor technical corrections to the insurance and real estate statutes.

*House Amendment "A" makes gender-neutral language and technical changes.

*House Amendment "B" extends the filing deadline to submit certain MCO data from May 1 to July 1 each year.

EFFECTIVE DATE: October 1, 1998

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Report
Yea 18 Nay 0