



House Bill No. 6618

Public Act No. 05-20

**AN ACT CONCERNING FEDERAL REQUIREMENTS FOR
MEDICARE SUPPLEMENT PLANS.**

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

Section 1. Section 38a-473 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or [any] other entity which delivers or issues for delivery Medicare supplement insurance policies or certificates, written, delivered, continued or renewed in this state during the previous calendar year [,] shall incorporate in its rates for Medicare supplement insurance calculated in accordance with sections 38a-495, 38a-495a and 38a-522, and any regulations adopted [thereunder] pursuant to said sections, factors for expenses which exceed one hundred fifty per cent of the average expense ratio for the entire written premium for all lines of health insurance of such company, society, corporation, center or other entity for the previous calendar year.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or [any] other entity which delivers or issues for delivery [,] in this state [,] any

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Medicare supplement policies or certificates [,] shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b, as amended by this act. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in [determining rates and granting] determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

Sec. 2. Section 38a-474 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) On [or] and after October 1, 1990, any insurance company, fraternal benefit society, hospital service corporation or medical service corporation, and on and after January 1, 1994, any health care center or [any] other entity which delivers, issues for delivery, continues or renews in this state any Medicare supplement policy or certificate, as defined in sections 38a-495, 38a-495a and 38a-522, seeking to change its rates [,] shall file a request for such change with the [insurance department] Insurance Department at least sixty days prior to the proposed effective date of such change. The Insurance Department shall review the request and, with respect to requests for an increase in rates, shall hold a public hearing on such increase. The Insurance Commissioner shall approve or deny the request [within] not later than forty-five days [of] after its receipt. The Insurance Commissioner shall adopt regulations, in accordance with [the provisions of] chapter 54, to set requirements for the submission of data pertaining to a request to change rates and to define the policies utilized in making a decision on such change in rates.

(b) No insurance company, fraternal benefit society, hospital service

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corporation, medical service corporation, health care center or [any] other entity which delivers or issues for delivery [,] in this state [,] any Medicare supplement policies or certificates [,] shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of the person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b, as amended by this act. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in [determining rates and granting] determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

Sec. 3. Section 38a-481 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection [therewith] with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. The commissioner shall adopt regulations, in accordance with [the provisions of] chapter 54, [establishing] to establish a procedure for [review of] reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer which has filed any such form of [his] the commissioner's disapproval, specifying [his] the reasons [therefore] for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

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(b) No rate filed under the provisions of subsection (a) of this section shall be effective until the expiration of thirty days after it has been filed or unless sooner approved by the commissioner in accordance with regulations [promulgated by him, which regulations shall] adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to insure that such rates shall not be excessive, inadequate or unfairly discriminatory. [and the] The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474, as amended by this act.

(c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or [any] other entity which delivers or issues for delivery [,] in this state [,] any Medicare supplement policies or certificates [,] shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b, as amended by this act. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in [determining rates and granting] determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(d) Rates on a particular policy form will not be deemed excessive if the insurer has filed a loss ratio guarantee with the Insurance Commissioner which meets the requirements of subsection (e) of this section provided (1) the form of such loss ratio guarantee has been explicitly approved by the Insurance Commissioner, and [provided

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further,] (2) the current expected lifetime loss ratio is not more than five per cent less than the filed lifetime loss ratio as certified by an actuary. The insurer shall withdraw the policy form if the commissioner determines that the lifetime loss ratio will not be met. Rates also will not be deemed excessive if the insurer complies with the terms of the loss ratio guarantee. The Insurance Commissioner may [, however,] adopt regulations, in accordance with chapter 54, to assure that the use of a loss ratio guarantee does not constitute an unfair practice.

(e) Premium rates shall be deemed approved upon filing with the Insurance Commissioner if the filing is accompanied by a loss ratio guarantee. The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and shall contain as a minimum the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(2) A guarantee that the actual Connecticut loss ratios for the experience period in which the new rates take effect and for each experience period thereafter until any new rates are filed will meet or exceed the loss ratios referred to in subdivision (1) of this subsection. If the annual earned premium volume in Connecticut under the particular policy form is less than one million dollars and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nation-wide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained;

(3) A guarantee that the actual Connecticut or [national, as the case may be,] nation-wide loss ratio results, as the case may be, for the experience period at issue will be independently audited by a certified

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public accountant or a member of the American Academy of Actuaries at the insurer's expense. The audit shall be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Insurance Commissioner not later than June thirtieth following the end of the experience period;

(4) A guarantee that affected Connecticut policyholders will be issued a proportional refund, which will be based on the premiums earned, of the amount necessary to bring the actual loss ratio up to the anticipated loss ratio referred to in subdivision (1) of this subsection. If nation-wide loss ratios are used, the total amount refunded in Connecticut [will] shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned from all Connecticut policyholders who will receive refunds and divided by the total premium earned in all states on the policy form. The refund shall be made to all Connecticut policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal two dollars or more. The refund [will] shall include interest, at six per cent, from the end of the experience period until the date of payment. Payment shall be made during the third quarter of the year following the experience period for which a refund is determined to be due;

(5) A guarantee that refunds less than two dollars will be aggregated by the insurer. The insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate [one-half of] such amount to The University of Connecticut Health Center; [and one-half of such amount to Uncas-on-Thames Hospital;]

(6) A guarantee that the insurer, if directed by the Insurance Commissioner, shall withdraw the policy form and cease the issuance

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of new policies under the form in this state if the applicable loss ratio exceeds the durational target loss ratio for the experience period by more than twenty per cent, provided the calculations are based on at least two thousand policyholder-years of experience either in [the state] Connecticut or nation-wide.

(f) For the purposes of this section:

(1) "Loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations; and

(2) "Experience period" means the calendar year for which a loss ratio guarantee is calculated.

(g) Nothing in this chapter shall preclude the issuance of an individual health insurance policy which includes an optional life insurance rider, provided [] the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

(h) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state on or after October 1, 2003, may (1) move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; or (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a

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whole.

Sec. 4. Section 38a-495b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) As used in sections 38a-473, as amended by this act, 38a-474, as amended by this act and 38a-481, as amended by this act, subsection (l) of section 38a-495a, sections 38a-495c, as amended by this act and 38a-513, as amended by this act and this section, "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended (Title I, Part I of P.L. 89-97). For policies or certificates delivered or issued for delivery to any resident of this state who is eligible for Medicare, prior to July 30, 1992, "Medicare supplement policy" means any individual or group health insurance policy or certificate delivered or issued for delivery to any resident of the state who is eligible for Medicare, except any long-term care policy as defined in sections 38a-501 and 38a-528. For policies or certificates delivered or issued for delivery to any resident on or after July 30, 1992, "Medicare supplement policy" means (A) a group or individual policy of accident and sickness insurance or (B) a subscriber contract of hospital and medical service corporations or health care centers, other than a policy issued pursuant to a contract under Section 1876 or Section 1833 of the federal Social Security Act (42 USC Section 1395 et seq.), or (C) an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(b) In accordance with the regulations adopted pursuant to section 38a-495a, on and after [July 30, 1992] July 1, 2005, there are [ten] standardized Medicare supplement insurance policies or certificates designated as plans "A" to ["J"] "L", inclusive.

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Sec. 5. Section 38a-495c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) [Any] Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or [any] other entity in this state, on or after January 1, 1994, which delivers, issues for delivery, continues or renews any Medicare supplement insurance policies or certificates shall base the premium rates charged on a community rate. Such rate shall not be based on age, gender, previous claims history or the medical condition of the person covered by such policy or certificate. Except as provided in subsection (c) of this section, coverage shall not be denied on the basis of age, gender, previous claim history or the medical condition of the person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b, as amended by this act. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in [determining rates and granting] determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(b) Nothing in this section shall prohibit an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or [any] other entity in this state issuing Medicare supplement insurance policies or certificates from using its usual and customary underwriting procedures, provided no such company, society, corporation, center or other entity shall issue a Medicare supplement policy or certificate based on the age, gender, previous claims history or the medical condition of the applicant, except that the previous claims history and the medical condition of the applicant may be used in [determining rates and granting] determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006, for plans "H" to "J", inclusive.

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(c) Nothing in this section shall prohibit an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or [any] other entity in this state when granting coverage under a Medicare supplement policy or certificate from excluding benefits for losses incurred within six months from the effective date of coverage based on a preexisting condition, in accordance with section 38a-495a and the regulations adopted pursuant to section 38a-495a.

(d) [Every] Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or certificates for plan "A", "B" or "C", or any combination thereof, to persons eligible for Medicare by reason of age, shall offer for sale the same such policies or certificates to persons eligible for Medicare by reason of disability.

(e) [Every] Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity in the state issuing Medicare supplement policies or certificates shall make all necessary arrangements with the Medicare Part B carrier and all Medicare Part A intermediaries to allow for the forwarding, to the issuing entity, of all Medicare claims containing the name of the entity issuing a Medicare supplement policy or certificate and the identification number of an insured. The entity issuing the Medicare supplement policy or certificate shall process all benefits available to an insured from a Medicare claim so forwarded, without requiring any additional action on the part of the insured.

(f) The provisions of this section shall apply to all Medicare supplement policies or certificates issued on and after January 1, 1994. For Medicare supplement policies or certificates issued prior to January 1, 1994, the provisions of this section shall apply as of the first

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rating period commencing on or after January 1, 1994, but no later than January 1, 1995.

(g) The Insurance Commissioner [shall] may adopt [such] regulations, [as he deems necessary,] in accordance with chapter 54, to [carry out the purposes of] implement this section.

Sec. 6. Section 38a-513 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2005*):

(a) No group health insurance policy, as defined by the commissioner, or certificate shall be issued or delivered in this state unless a copy of the form [thereof] for such policy or certificate has been submitted to and approved by the commissioner under [such reasonable regulations as he makes concerning the provisions in such contracts and their submission to and approval by him] the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with [the provisions of] chapter 54, [establishing] concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for [review of] reviewing such policies and certificates. If the commissioner issues an order disapproving the use of such form, the provisions of section 38a-19 shall apply to such order.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or [any] other entity which delivers or issues for delivery [,] in this state [,] any Medicare supplement policies or certificates [,] shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b, as amended by this act. In

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plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in [determining rates and granting] determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(c) Nothing in this chapter shall preclude the issuance of a group health insurance policy which includes an optional life insurance rider, provided [,] the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

Approved May 9, 2005