



House of Representatives

General Assembly

File No. 201

January Session, 2005

House Bill No. 6618

House of Representatives, April 6, 2005

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING FEDERAL REQUIREMENTS FOR MEDICARE SUPPLEMENT PLANS.

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

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 Section 38a-473 of the general statutes is repealed and the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

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

14 for the previous calendar year.

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

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 Section 38a-474 of the general statutes is repealed and the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

30 (a) On [or] and after October 1, 1990, any insurance company,
31 fraternal benefit society, hospital service corporation or medical service
32 corporation, and on and after January 1, 1994, any health care center or
33 [any] other entity which delivers, issues for delivery, continues or
34 renews in this state any Medicare supplement policy or certificate, as
35 defined in sections 38a-495, 38a-495a and 38a-522, seeking to change its
36 rates [,] shall file a request for such change with the [insurance
37 department] Insurance Department at least sixty days prior to the
38 proposed effective date of such change. The Insurance Department
39 shall review the request and, with respect to requests for an increase in
40 rates, shall hold a public hearing on such increase. The Insurance
41 Commissioner shall approve or deny the request [within] not later
42 than forty-five days [of] after its receipt. The Insurance Commissioner
43 shall adopt regulations, in accordance with [the provisions of] chapter
44 54, to set requirements for the submission of data pertaining to a
45 request to change rates and to define the policies utilized in making a
46 decision on such change in rates.

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

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

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

79 (b) No rate filed under the provisions of subsection (a) of this

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

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

105 (d) Rates on a particular policy form will not be deemed excessive if
106 the insurer has filed a loss ratio guarantee with the Insurance
107 Commissioner which meets the requirements of subsection (e) of this
108 section provided (1) the form of such loss ratio guarantee has been
109 explicitly approved by the Insurance Commissioner, and [provided
110 further,] (2) the current expected lifetime loss ratio is not more than
111 five per cent less than the filed lifetime loss ratio as certified by an
112 actuary. The insurer shall withdraw the policy form if the
113 commissioner determines that the lifetime loss ratio will not be met.

114 Rates also will not be deemed excessive if the insurer complies with
115 the terms of the loss ratio guarantee. The Insurance Commissioner may
116 [~~however,~~] adopt regulations, in accordance with chapter 54, to
117 assure that the use of a loss ratio guarantee does not constitute an
118 unfair practice.

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

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

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

137 (3) A guarantee that the actual Connecticut or [~~national,~~ as the case
138 may be,] nation-wide loss ratio results, as the case may be, for the
139 experience period at issue will be independently audited by a certified
140 public accountant or a member of the American Academy of Actuaries
141 at the insurer's expense. The audit shall be done in the second quarter
142 of the year following the end of the experience period and the audited
143 results must be reported to the Insurance Commissioner not later than
144 June thirtieth following the end of the experience period;

145 (4) A guarantee that affected Connecticut policyholders will be

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

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

168 (6) A guarantee that the insurer, if directed by the Insurance
169 Commissioner, shall withdraw the policy form and cease the issuance
170 of new policies under the form in this state if the applicable loss ratio
171 exceeds the durational target loss ratio for the experience period by
172 more than twenty per cent, provided the calculations are based on at
173 least two thousand policyholder-years of experience either in [the
174 state] Connecticut or nation-wide.

175 (f) For the purposes of this section:

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

178 durations; and

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

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

188 (h) No insurance company, fraternal benefit society, hospital service
189 corporation, medical service corporation, health care center or other
190 entity which delivers, issues for delivery, amends, renews or continues
191 an individual health insurance policy in this state on or after October 1,
192 2003, may (1) move an insured individual from a standard
193 underwriting classification to a substandard underwriting
194 classification after the policy is issued; or (2) increase premium rates
195 due to the claim experience or health status of an individual who is
196 insured under the policy, except that the entity may increase premium
197 rates for all individuals in an underwriting classification due to the
198 claim experience or health status of the underwriting classification as a
199 whole.

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

202 (a) As used in sections 38a-473, as amended by this act, 38a-474, as
203 amended by this act and 38a-481, as amended by this act, subsection (l)
204 of section 38a-495a, sections 38a-495c, as amended by this act and 38a-
205 513, as amended by this act and this section, "Medicare" means the
206 Health Insurance for the Aged Act, Title XVIII of the Social Security
207 Amendments of 1965, as amended (Title I, Part I of P.L. 89-97). For
208 policies or certificates delivered or issued for delivery to any resident
209 of this state who is eligible for Medicare, prior to July 30, 1992,

210 "Medicare supplement policy" means any individual or group health
211 insurance policy or certificate delivered or issued for delivery to any
212 resident of the state who is eligible for Medicare, except any long-term
213 care policy as defined in sections 38a-501 and 38a-528. For policies or
214 certificates delivered or issued for delivery to any resident on or after
215 July 30, 1992, "Medicare supplement policy" means (A) a group or
216 individual policy of accident and sickness insurance or (B) a subscriber
217 contract of hospital and medical service corporations or health care
218 centers, other than a policy issued pursuant to a contract under Section
219 1876 or Section 1833 of the federal Social Security Act (42 USC Section
220 1395 et seq.), or (C) an issued policy under a demonstration project
221 authorized pursuant to amendments to the federal Social Security Act,
222 which is advertised, marketed or designed primarily as a supplement
223 to reimbursements under Medicare for the hospital, medical or
224 surgical expenses of persons eligible for Medicare.

225 (b) In accordance with the regulations adopted pursuant to section
226 38a-495a, on and after ~~[July 30, 1992]~~ July 1, 2005, there are ~~[ten]~~
227 standardized Medicare supplement insurance policies or certificates
228 designated as plans "A" to ~~["J"]~~ "L", inclusive.

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

231 (a) ~~[Any]~~ Each insurance company, fraternal benefit society, hospital
232 service corporation, medical service corporation, health care center or
233 ~~[any]~~ other entity in this state, on or after January 1, 1994, which
234 delivers, issues for delivery, continues or renews any Medicare
235 supplement insurance policies or certificates shall base the premium
236 rates charged on a community rate. Such rate shall not be based on
237 age, gender, previous claims history or the medical condition of the
238 person covered by such policy or certificate. Except as provided in
239 subsection (c) of this section, coverage shall not be denied on the basis
240 of age, gender, previous claim history or the medical condition of the
241 person covered by such policy or certificate, except for plans "H" to "J",
242 inclusive, as provided in section 38a-495b, as amended by this act. In

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

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

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

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

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

286 (f) The provisions of this section shall apply to all Medicare
287 supplement policies or certificates issued on and after January 1, 1994.
288 For Medicare supplement policies or certificates issued prior to
289 January 1, 1994, the provisions of this section shall apply as of the first
290 rating period commencing on or after January 1, 1994, but no later than
291 January 1, 1995.

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

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

297 (a) No group health insurance policy, as defined by the
298 commissioner, or certificate shall be issued or delivered in this state
299 unless a copy of the form [thereof] for such policy or certificate has
300 been submitted to and approved by the commissioner under [such
301 reasonable regulations as he makes concerning the provisions in such
302 contracts and their submission to and approval by him] the regulations
303 adopted pursuant to this section. The commissioner shall adopt
304 regulations, in accordance with [the provisions of] chapter 54,
305 [establishing] concerning the provisions, submission and approval of
306 such policies and certificates and establishing a procedure for [review

307 of] reviewing such policies and certificates. If the commissioner issues
 308 an order disapproving the use of such form, the provisions of section
 309 38a-19 shall apply to such order.

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2005	38a-473
Sec. 2	July 1, 2005	38a-474
Sec. 3	July 1, 2005	38a-481
Sec. 4	July 1, 2005	38a-495b
Sec. 5	July 1, 2005	38a-495c
Sec. 6	July 1, 2005	38a-513

INS *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 06 \$	FY 07 \$
Insurance Dept.	IF - None	None	None

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill revises the Medicare supplement policy requirements due to federal law changes that take effect January 1, 2006. The bill also makes other technical changes, none of which have a fiscal impact.

OLR Bill Analysis

HB 6618

**AN ACT CONCERNING FEDERAL REQUIREMENTS FOR
MEDICARE SUPPLEMENT PLANS****SUMMARY:**

This bill revises Medicare supplement policy requirements due to federal law changes that take effect January 1, 2006. It requires insurers and HMOs to issue all Medicare supplement policies on a guaranteed issue basis (i.e., with no regard to a person's age, gender, claim history, or medical condition) as of January 1, 2006 by eliminating the exception to the requirement for plans H, I, and J. The bill permits insurers and HMOs to still consider a person's claims history and medical condition when deciding to issue plans H, I, and J to applicants prior to January 1, 2006.

The bill also eliminates authority for insurers and HMOs to consider claims history and medical condition when establishing rates for plans H, I, and J. Thus, it requires insurers and HMOs to community rate all Medicare supplement plans, since plans A through G must already be community rated by law.

The bill permits, instead of requires, the insurance commissioner to adopt regulations regarding Medicare Supplement plans. It eliminates a reference to 10 standardized Medicare supplement policies, replacing it with a reference to 12 plans, "A" through "L."

The bill also makes technical changes and a minor change regarding loss ratio premium refunds.

EFFECTIVE DATE: July 1, 2005

LOSS RATIO PREMIUM REFUND DONATIONS

This bill requires that loss ratio premium refunds held in an interest-bearing account by law be donated in total to the University of Connecticut Health Center, instead of split between the University of

Connecticut Health Center and Uncas-on-Thames Hospital, as the Uncas-on-Thames Hospital is defunct.

BACKGROUND

Medicare Supplement Policies

A Medicare supplement policy (also referred to as “Medigap”) is a health insurance policy sold by private insurance companies to cover some of the health care costs that Medicare does not cover. Currently, there are 10 standard Medicare supplement policies called plans “A” through “J.” Plan A covers only basic benefits. Plans B through J offer additional benefits, with Plan J offering the most. States retain regulatory authority over these policies if the policies meet minimum standards set forth in federal law and by the National Association of Insurance Commissioners.

Medicare Modernization Act of 2003

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P. L. 108-173) (“MMA”) establishes Medicare Part D, which provides prescription drug coverage for seniors. As of January 1, 2006, no new Medicare supplement plans will be sold with prescription drug coverage. If a person enrolls in a Medicare supplement policy that currently covers prescription drugs (i.e., plans H, I, or J) by December 31, 2005, he can keep that policy with the drug coverage if he does not enroll in Medicare’s Prescription Drug Benefit (Medicare Part D), which begins in 2006. If he chooses to enroll in a Medicare Prescription Drug Benefit plan, he can keep the supplement policy but the drug coverage will be removed from it.

MMA also creates two new Medicare supplement plans, K and L, which include reduced first dollar coverage. One will cover 50% of the cost-sharing required under Medicare Parts A and B and limit out-of-pocket expenses to \$4,000, subject to an annual inflationary adjustment. The other will cover 75% of the cost-sharing and limit out-of-pocket expenses to \$2,000.

Community Rating

Community rating is the process of developing a uniform rate for all enrollees. Often community rates may vary based only on geographical location.

Loss Ratio

Loss ratio is the ratio between insurance losses sustained and premiums earned in a given period. By law, the insurance commissioner approves a Medicare supplement premium rate filing if it includes a guarantee that actual loss ratios will meet or exceed a specified anticipated loss ratio. The anticipated loss ratio must be at least 65%. If the target is not met, an insurer is required to refund premium to Connecticut policyholders as necessary to bring the actual loss ratio up to the guaranteed level. Refunds less than two dollars must be aggregated by the insurer and deposited in an interest-bearing account. At each calendar year end, the insurer is required to donate the fund as specified by law.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Report

Yea 15 Nay 0