



General Assembly

January Session, 2005

**Raised Bill No. 6618**

LCO No. 3043

\*            HB06618INS            032205            \*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

**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 Section 38a-473 of the general statutes is repealed and the  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 Section 38a-474 of the general statutes is repealed and the  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<sub>2</sub> 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	<i>July 1, 2005</i>	38a-473
Sec. 2	<i>July 1, 2005</i>	38a-474
Sec. 3	<i>July 1, 2005</i>	38a-481

Sec. 4	<i>July 1, 2005</i>	38a-495b
Sec. 5	<i>July 1, 2005</i>	38a-495c
Sec. 6	<i>July 1, 2005</i>	38a-513

**INS**      *Joint Favorable*