



General Assembly

**Substitute Bill No. 1214**

January Session, 2007

\* SB01214JUD\_\_043007\_\_ \*

**AN ACT CONCERNING POSTCLAIMS UNDERWRITING.**

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

1 Section 1. (NEW) (*Effective October 1, 2007*) (a) No health insurer or  
2 health care center issuing or providing any policy of insurance or  
3 contract providing coverage of the type specified in subdivisions (1),  
4 (2), (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes  
5 shall engage in the practice of postclaims underwriting. For purposes  
6 of this section, "postclaims underwriting" means the rescinding,  
7 canceling or limiting of a policy, contract, certificate or evidence of  
8 coverage due to the insurer's or health care center's failure to complete  
9 medical underwriting and resolve all reasonable medical questions  
10 arising from written information submitted on or with, or omitted  
11 from, an application before issuing the policy, contract, certificate or  
12 evidence of coverage.

13 (b) No health insurer or health care center shall rescind, cancel or  
14 limit a policy, contract, certificate or evidence of coverage based on  
15 written information submitted on or with, or omitted from, an  
16 application unless it proves to the Insurance Commissioner that such  
17 information is false and was provided by the applicant or such  
18 applicant's representative with knowledge of the falsity therein or such  
19 statement or omission materially affects the risk or the hazard assumed  
20 by the health insurer or health care center. The commissioner shall

21 provide the applicant or such applicant's representative with an  
22 opportunity to respond to information submitted by the health insurer  
23 or health care center to the commissioner pursuant to this section. No  
24 rescission, cancellation or limitation under this subsection shall occur  
25 more than two years after the effective date of the policy, contract,  
26 certificate or evidence of coverage.

27 (c) Any violation of the provisions of this section shall be deemed an  
28 unfair or deceptive insurance practice under section 38-816 of the  
29 general statutes.

30 Sec. 2. Section 38a-476 of the general statutes is repealed and the  
31 following is substituted in lieu thereof (*Effective October 1, 2007*):

32 (a) (1) For the purposes of this section, "health insurance plan"  
33 means any hospital and medical expense incurred policy, hospital or  
34 medical service plan contract and health care center subscriber contract  
35 and does not include (A) [short-term health insurance issued on a  
36 nonrenewable basis with a duration of six months or less,] accident  
37 only, credit, dental, vision, Medicare supplement, long-term care or  
38 disability insurance, hospital indemnity coverage, coverage issued as a  
39 supplement to liability insurance, insurance arising out of a workers'  
40 compensation or similar law, automobile medical payments insurance,  
41 or insurance under which beneficiaries are payable without regard to  
42 fault and which is statutorily required to be contained in any liability  
43 insurance policy or equivalent self-insurance, or (B) policies of  
44 specified disease or limited benefit health insurance, provided that the  
45 carrier offering such policies files on or before March first of each year  
46 a certification with the Insurance Commissioner that contains the  
47 following: (i) A statement from the carrier certifying that such policies  
48 are being offered and marketed as supplemental health insurance and  
49 not as a substitute for hospital or medical expense insurance; (ii) a  
50 summary description of each such policy including the average annual  
51 premium rates, or range of premium rates in cases where premiums  
52 vary by age, gender or other factors, charged for such policies in the  
53 state; and (iii) in the case of a policy that is described in this

54 subparagraph and that is offered for the first time in this state on or  
55 after October 1, 1993, the carrier files with the commissioner the  
56 information and statement required in this subparagraph at least thirty  
57 days prior to the date such policy is issued or delivered in this state.

58 (2) "Insurance arrangement" means any "multiple employer welfare  
59 arrangement", as defined in Section 3 of the Employee Retirement  
60 Income Security Act of 1974 (ERISA), as amended, except for any such  
61 arrangement which is fully insured within the meaning of Section  
62 514(b)(6) of said act, as amended.

63 (3) "Preexisting conditions provision" means a policy provision  
64 which limits or excludes benefits relating to a condition based on the  
65 fact that the condition was present before the effective date of  
66 coverage, for which any medical advice, diagnosis, care or treatment  
67 was recommended or received before such effective date. Routine  
68 follow-up care to determine whether a breast cancer has reoccurred in  
69 a person who has been previously determined to be breast cancer free  
70 shall not be considered as medical advice, diagnosis, care or treatment  
71 for purposes of this section unless evidence of breast cancer is found  
72 during or as a result of such follow-up. Genetic information shall not  
73 be treated as a condition in the absence of a diagnosis of the condition  
74 related to such information. Pregnancy shall not be considered a  
75 preexisting condition.

76 (4) "Qualifying coverage" means (A) any group health insurance  
77 plan, insurance arrangement or self-insured plan, (B) Medicare or  
78 Medicaid, or (C) an individual health insurance plan that provides  
79 benefits which are actuarially equivalent to or exceeding the benefits  
80 provided under the small employer health care plan, as defined in  
81 subdivision (12) of section 38a-564, whether issued in this state or any  
82 other state.

83 (5) "Applicable waiting period" means the period of time imposed  
84 by the group policyholder or contractholder before an individual is  
85 eligible for participating in the group policy or contract.

86 (b) (1) No group health insurance plan or insurance arrangement  
87 may impose a preexisting conditions provision which excludes  
88 coverage for a period beyond twelve months following the insured's  
89 effective date of coverage. Any preexisting conditions provision may  
90 only relate to conditions, whether physical or mental, for which  
91 medical advice, diagnosis or care or treatment was recommended or  
92 received during the six months immediately preceding the effective  
93 date of coverage.

94 (2) No individual health insurance plan or insurance arrangement  
95 may impose a preexisting conditions provision which excludes  
96 coverage beyond twelve months following the insured's effective date  
97 of coverage. Any preexisting conditions provision may only relate to  
98 conditions, whether physical or mental, [which manifest themselves,  
99 or] for which medical advice, diagnosis or care or treatment was  
100 recommended or received during the twelve months immediately  
101 preceding the effective date of coverage.

102 (c) All health insurance plans and insurance arrangements shall  
103 provide coverage, under the terms and conditions of their policies or  
104 contracts, for the preexisting conditions of any newly insured  
105 individual who was previously covered for such preexisting condition  
106 under the terms of the individual's preceding qualifying coverage,  
107 provided the preceding coverage was continuous to a date less than  
108 one hundred twenty days prior to the effective date of the new  
109 coverage, exclusive of any applicable waiting period, except in the case  
110 of a newly insured group member whose previous coverage was  
111 terminated due to an involuntary loss of employment, the preceding  
112 coverage must have been continuous to a date not more than one  
113 hundred fifty days prior to the effective date of the new coverage,  
114 exclusive of any applicable waiting period, provided such newly  
115 insured group member or dependent applies for such succeeding  
116 coverage within thirty days of the member's or dependent's initial  
117 eligibility.

118 (d) With respect to a newly insured individual who was previously

119 covered under qualifying coverage, but who was not covered under  
120 such qualifying coverage for a preexisting condition, as defined under  
121 the new health insurance plan or arrangement, such plan or  
122 arrangement shall credit the time such individual was previously  
123 covered by qualifying coverage to the exclusion period of the  
124 preexisting condition provision, provided the preceding coverage was  
125 continuous to a date less than one hundred twenty days prior to the  
126 effective date of the new coverage, exclusive of any applicable waiting  
127 period under such plan, except in the case of a newly insured group  
128 member whose preceding coverage was terminated due to an  
129 involuntary loss of employment, the preceding coverage must have  
130 been continuous to a date not more than one hundred fifty days prior  
131 to the effective date of the new coverage, exclusive of any applicable  
132 waiting period, provided such newly insured group member or  
133 dependent applies for such succeeding coverage within thirty days of  
134 the member's or dependent's initial eligibility.

135 (e) Each insurance company, fraternal benefit society, hospital  
136 service corporation, medical service corporation or health care center  
137 which issues in this state group health insurance subject to Section  
138 2701 of the Public Health Service Act, as set forth in the Health  
139 Insurance Portability and Accountability Act of 1996 (P.L. 104-191)  
140 (HIPAA), as amended from time to time, shall comply with the  
141 provisions of said section with respect to such group health insurance,  
142 except that the longer period of days specified in subsections (c) and  
143 (d) of this section shall apply to the extent excepted from preemption  
144 in Section 2723(B)(2)(iii) of said Public Health Service Act.

145 (f) The provisions of this section shall apply to every health  
146 insurance plan or insurance arrangement issued, renewed or  
147 continued in this state on or after October 1, 1993. For purposes of this  
148 section, the date a plan or arrangement is continued shall be the  
149 anniversary date of the issuance of the plan or arrangement. The  
150 provisions of subsection (e) of this section shall apply on and after the  
151 dates specified in Sections 2747 and 2792 of the Public Health Service  
152 Act as set forth in HIPAA.

153 (g) A short-term health insurance policy issued on a nonrenewable  
154 basis for six months or less shall [not] be subject to this section. [,  
155 provided, any policy, application or sales brochure issued for such  
156 short-term insurance which imposes a preexisting conditions provision  
157 shall disclose that such preexisting conditions are not covered.] For the  
158 purposes of this subsection, "nonrenewable basis" means only those  
159 policies that are issued with a lapse in coverage of more than thirty  
160 days between an earlier policy and a subsequent policy being issued  
161 by the same insurer or health care center to the same individual  
162 policyholder.

163 (h) The commissioner may adopt regulations, in accordance with  
164 the provisions of chapter 54, to enforce the provisions of HIPAA  
165 concerning preexisting conditions and portability.

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| This act shall take effect as follows and shall amend the following sections: |                 |             |
| Section 1   | October 1, 2007 | New section |
| Sec. 2  | October 1, 2007 | 38a-476     |

**INS**      *Joint Favorable Subst.*

**JUD**      *Joint Favorable*