



General Assembly

January Session, 2007

Amendment

LCO No. 7607

SB0121407607SD0

Offered by:

SEN. CRISCO, 17th Dist.

REP. O'CONNOR, 35th Dist.

To: Subst. Senate Bill No. **1214**

File No. 112

Cal. No. 154

"AN ACT CONCERNING POSTCLAIMS UNDERWRITING."

1 Strike everything after the enacting clause and insert the following
2 in lieu thereof:

3 "Section 1. (NEW) (*Effective October 1, 2007*) (a) Unless approval is
4 granted pursuant to subsection (b) of this section, no insurer or health
5 care center may rescind, cancel or limit any policy of insurance,
6 contract, evidence of coverage or certificate that provides coverage of
7 the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of
8 section 38a-469 of the general statutes on the basis of written
9 information submitted on, with or omitted from an insurance
10 application by the insured if the insurer or health care center failed to
11 complete medical underwriting and resolve all reasonable medical
12 questions related to the written information submitted on, with or
13 omitted from the insurance application before issuing the policy,
14 contract, evidence of coverage or certificate. No insurer or health care
15 center may rescind, cancel or limit any such policy, contract, evidence

16 of coverage or certificate more than two years after the effective date of
17 the policy, contract, evidence of coverage or certificate.

18 (b) An insurer or health care center shall apply for approval of such
19 rescission, cancellation or limitation by submitting such written
20 information to the Insurance Commissioner on an application in such
21 form as the commissioner prescribes. Such insurer or health care center
22 shall provide a copy of the application for such approval to the insured
23 or the insured's representative. Not later than seven business days
24 after receipt of the application for such approval, the insured or the
25 insured's representative shall have an opportunity to review such
26 application and respond and submit relevant information to the
27 commissioner with respect to such application. Not later than fifteen
28 business days after the submission of information by the insured or the
29 insured's representative, the commissioner shall issue a written
30 decision on such application. The commissioner may approve such
31 rescission, cancellation or limitation if the commissioner finds that (1)
32 the written information submitted on or with the insurance application
33 was false at the time such application was made and the insured or
34 such insured's representative knew or should have known of the
35 falsity therein, and such submission materially affects the risk or the
36 hazard assumed by the insurer or health care center, or (2) the
37 information omitted from the insurance application was knowingly
38 omitted by the insured or such insured's representative, or the insured
39 or such insured's representative should have known of such omission,
40 and such omission materially affects the risk or the hazard assumed by
41 the insurer or health care center. Such decision shall be mailed to the
42 insured, the insured's representative, if any, and the insurer or health
43 care center.

44 (c) Notwithstanding the provisions of chapter 54 of the general
45 statutes, any insurer or insured aggrieved by any decision by the
46 commissioner under subsection (b) of this section may, within thirty
47 days after notice of the commissioner's decision is mailed to such
48 insurer and insured, take an appeal therefrom to the superior court for
49 the judicial district of Hartford, which shall be accompanied by a

50 citation to the commissioner to appear before said court. Such citation
51 shall be signed by the same authority, and such appeal shall be
52 returnable at the same time and served and returned in the same
53 manner, as is required in case of a summons in a civil action. Said court
54 may grant such relief as may be equitable.

55 (d) The Insurance Commissioner may adopt regulations, in
56 accordance with chapter 54 of the general statutes, to implement the
57 provisions of this section.

58 Sec. 2. Section 38a-19 of the general statutes is repealed and the
59 following is substituted in lieu thereof (*Effective October 1, 2007*):

60 (a) Any person or insurer aggrieved by any order or decision of the
61 commissioner made without a hearing may, not later than thirty days
62 after notice of the order to the person or insurer, make written request
63 to the commissioner for a hearing on the order or decision. The
64 commissioner shall hear such party or parties not later than thirty days
65 after receipt of such request and shall give not less than ten days'
66 written notice of the time and place of the hearing. Not later than forty-
67 five days after such hearing, the commissioner shall affirm, reverse or
68 modify his previous order or decision, specifying his reasons therefor.
69 Pending such hearing and decision on such hearing the commissioner
70 may suspend or postpone the effective date of his previous order or
71 decision.

72 (b) Nothing contained in this section or sections 38a-363 to 38a-388,
73 inclusive, shall require the observance at any hearing of formal rules of
74 pleading or evidence.

75 (c) The provisions of this section shall not apply to an order or
76 decision of the commissioner made pursuant to section 38a-478n or
77 section 1 of this act.

78 (d) Any order or decision of the commissioner shall be subject to
79 appeal therefrom in accordance with the provisions of section 4-183.

80 Sec. 3. Section 38a-476 of the general statutes is repealed and the
81 following is substituted in lieu thereof (*Effective October 1, 2007*):

82 (a) (1) For the purposes of this section, "health insurance plan"
83 means any hospital and medical expense incurred policy, hospital or
84 medical service plan contract and health care center subscriber contract
85 and does not include (A) short-term health insurance issued on a
86 nonrenewable basis with a duration of six months or less, accident
87 only, credit, dental, vision, Medicare supplement, long-term care or
88 disability insurance, hospital indemnity coverage, coverage issued as a
89 supplement to liability insurance, insurance arising out of a workers'
90 compensation or similar law, automobile medical payments insurance,
91 or insurance under which beneficiaries are payable without regard to
92 fault and which is statutorily required to be contained in any liability
93 insurance policy or equivalent self-insurance, or (B) policies of
94 specified disease or limited benefit health insurance, provided that the
95 carrier offering such policies files on or before March first of each year
96 a certification with the Insurance Commissioner that contains the
97 following: (i) A statement from the carrier certifying that such policies
98 are being offered and marketed as supplemental health insurance and
99 not as a substitute for hospital or medical expense insurance; (ii) a
100 summary description of each such policy including the average annual
101 premium rates, or range of premium rates in cases where premiums
102 vary by age, gender or other factors, charged for such policies in the
103 state; and (iii) in the case of a policy that is described in this
104 subparagraph and that is offered for the first time in this state on or
105 after October 1, 1993, the carrier files with the commissioner the
106 information and statement required in this subparagraph at least thirty
107 days prior to the date such policy is issued or delivered in this state.

108 (2) "Insurance arrangement" means any "multiple employer welfare
109 arrangement", as defined in Section 3 of the Employee Retirement
110 Income Security Act of 1974 (ERISA), as amended, except for any such
111 arrangement which is fully insured within the meaning of Section
112 514(b)(6) of said act, as amended.

113 (3) "Preexisting conditions provision" means a policy provision
114 which limits or excludes benefits relating to a condition based on the
115 fact that the condition was present before the effective date of
116 coverage, for which any medical advice, diagnosis, care or treatment
117 was recommended or received before such effective date. Routine
118 follow-up care to determine whether a breast cancer has reoccurred in
119 a person who has been previously determined to be breast cancer free
120 shall not be considered as medical advice, diagnosis, care or treatment
121 for purposes of this section unless evidence of breast cancer is found
122 during or as a result of such follow-up. Genetic information shall not
123 be treated as a condition in the absence of a diagnosis of the condition
124 related to such information. Pregnancy shall not be considered a
125 preexisting condition.

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

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

136 (b) (1) No group health insurance plan or insurance arrangement
137 may impose a preexisting conditions provision which excludes
138 coverage for a period beyond twelve months following the insured's
139 effective date of coverage. Any preexisting conditions provision may
140 only relate to conditions, whether physical or mental, for which
141 medical advice, diagnosis or care or treatment was recommended or
142 received during the six months immediately preceding the effective
143 date of coverage.

144 (2) No individual health insurance plan or insurance arrangement

145 may impose a preexisting conditions provision which excludes
146 coverage beyond twelve months following the insured's effective date
147 of coverage. Any preexisting conditions provision may only relate to
148 conditions, whether physical or mental, [which manifest themselves,
149 or] for which medical advice, diagnosis or care or treatment was
150 recommended or received during the twelve months immediately
151 preceding the effective date of coverage.

152 (c) All health insurance plans and insurance arrangements shall
153 provide coverage, under the terms and conditions of their policies or
154 contracts, for the preexisting conditions of any newly insured
155 individual who was previously covered for such preexisting condition
156 under the terms of the individual's preceding qualifying coverage,
157 provided the preceding coverage was continuous to a date less than
158 one hundred twenty days prior to the effective date of the new
159 coverage, exclusive of any applicable waiting period, except in the case
160 of a newly insured group member whose previous coverage was
161 terminated due to an involuntary loss of employment, the preceding
162 coverage must have been continuous to a date not more than one
163 hundred fifty days prior to the effective date of the new coverage,
164 exclusive of any applicable waiting period, provided such newly
165 insured group member or dependent applies for such succeeding
166 coverage within thirty days of the member's or dependent's initial
167 eligibility.

168 (d) With respect to a newly insured individual who was previously
169 covered under qualifying coverage, but who was not covered under
170 such qualifying coverage for a preexisting condition, as defined under
171 the new health insurance plan or arrangement, such plan or
172 arrangement shall credit the time such individual was previously
173 covered by qualifying coverage to the exclusion period of the
174 preexisting condition provision, provided the preceding coverage was
175 continuous to a date less than one hundred twenty days prior to the
176 effective date of the new coverage, exclusive of any applicable waiting
177 period under such plan, except in the case of a newly insured group
178 member whose preceding coverage was terminated due to an

179 involuntary loss of employment, the preceding coverage must have
180 been continuous to a date not more than one hundred fifty days prior
181 to the effective date of the new coverage, exclusive of any applicable
182 waiting period, provided such newly insured group member or
183 dependent applies for such succeeding coverage within thirty days of
184 the member's or dependent's initial eligibility.

185 (e) Each insurance company, fraternal benefit society, hospital
186 service corporation, medical service corporation or health care center
187 which issues in this state group health insurance subject to Section
188 2701 of the Public Health Service Act, as set forth in the Health
189 Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
190 (HIPAA), as amended from time to time, shall comply with the
191 provisions of said section with respect to such group health insurance,
192 except that the longer period of days specified in subsections (c) and
193 (d) of this section shall apply to the extent excepted from preemption
194 in Section 2723(B)(2)(iii) of said Public Health Service Act.

195 (f) The provisions of this section shall apply to every health
196 insurance plan or insurance arrangement issued, renewed or
197 continued in this state on or after October 1, 1993. For purposes of this
198 section, the date a plan or arrangement is continued shall be the
199 anniversary date of the issuance of the plan or arrangement. The
200 provisions of subsection (e) of this section shall apply on and after the
201 dates specified in Sections 2747 and 2792 of the Public Health Service
202 Act as set forth in HIPAA.

203 (g) [A] Notwithstanding the provisions of subsection (a) of this
204 section, a short-term health insurance policy issued on a nonrenewable
205 basis for six months or less which imposes a preexisting conditions
206 provision shall [not be subject to this section, provided, any policy,
207 application or sales brochure issued for such short-term insurance
208 which imposes a preexisting conditions provision shall disclose that
209 such preexisting conditions are not covered] be subject to the following
210 conditions: (1) No such preexisting conditions provision shall exclude
211 coverage beyond twelve months following the insured's effective date

212 of coverage; (2) such preexisting conditions provision may only relate
 213 to conditions, whether physical or mental, for which medical advice,
 214 diagnosis, care or treatment was recommended or received during the
 215 twenty-four months immediately preceding the effective date of
 216 coverage; and (3) any policy, application or sales brochure issued for
 217 such short-term health insurance policy that imposes such preexisting
 218 conditions provision shall disclose in a conspicuous manner in not less
 219 than fourteen-point bold face type the following statement:

220 "THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR
 221 WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT
 222 WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-
 223 FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE
 224 DATE OF COVERAGE."

225 In the event an insurer or health care center issues two consecutive
 226 short-term health insurance policies on a nonrenewable basis for six
 227 months or less which imposes a preexisting conditions provision to the
 228 same individual, the insurer or health care center shall reduce the
 229 preexisting conditions exclusion period in the second policy by the
 230 period of time such individual was covered under the first policy. If
 231 the same insurer or health care center issues a third or subsequent such
 232 short-term health insurance policy to the same individual, such insurer
 233 or health care center shall reduce the preexisting conditions exclusion
 234 period in the third or subsequent policy by the cumulative time
 235 covered under the prior policies. Nothing in this section shall be
 236 construed to require such short-term health insurance policy to be
 237 issued on a guaranteed issue or guaranteed renewable basis.

238 (h) The commissioner may adopt regulations, in accordance with
 239 the provisions of chapter 54, to enforce the provisions of HIPAA and
 240 this section concerning preexisting conditions and portability."

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2007	New section

Sec. 2	<i>October 1, 2007</i>	38a-19
Sec. 3	<i>October 1, 2007</i>	38a-476