



General Assembly

January Session, 2007

**Amendment**

LCO No. 7369

**\*SB0121407369SD0\***

Offered by:  
SEN. CRISCO, 17<sup>th</sup> 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 health insurer or  
5      health 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 health insurer or  
15     health care center may rescind, cancel or limit any such policy,  
16     contract, evidence of coverage or certificate more than two years after

17 the effective date of the policy, contract, evidence of coverage or  
18 certificate.

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

41 (c) Notwithstanding the provisions of chapter 54 of the general  
42 statutes, any insurer or insured aggrieved by any decision by the  
43 commissioner under subsection (b) of this section may, within thirty  
44 days after notice of the commissioner's decision is mailed to such  
45 insurer and insured, take an appeal therefrom to the superior court for  
46 the judicial district of Hartford, which shall be accompanied by a  
47 citation to the commissioner to appear before said court. Such citation  
48 shall be signed by the same authority, and such appeal shall be  
49 returnable at the same time and served and returned in the same  
50 manner, as is required in case of a summons in a civil action. Said court

51 may grant such relief as may be equitable.

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

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

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

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

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

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

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

79 (a) (1) For the purposes of this section, "health insurance plan"  
80 means any hospital and medical expense incurred policy, hospital or

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

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

110 (3) "Preexisting conditions provision" means a policy provision  
111 which limits or excludes benefits relating to a condition based on the  
112 fact that the condition was present before the effective date of  
113 coverage, for which any medical advice, diagnosis, care or treatment  
114 was recommended or received before such effective date. Routine

115 follow-up care to determine whether a breast cancer has reoccurred in  
116 a person who has been previously determined to be breast cancer free  
117 shall not be considered as medical advice, diagnosis, care or treatment  
118 for purposes of this section unless evidence of breast cancer is found  
119 during or as a result of such follow-up. Genetic information shall not  
120 be treated as a condition in the absence of a diagnosis of the condition  
121 related to such information. Pregnancy shall not be considered a  
122 preexisting condition.

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

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

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

141 (2) No individual health insurance plan or insurance arrangement  
142 may impose a preexisting conditions provision which excludes  
143 coverage beyond twelve months following the insured's effective date  
144 of coverage. Any preexisting conditions provision may only relate to  
145 conditions, whether physical or mental, [which manifest themselves,  
146 or] for which medical advice, diagnosis or care or treatment was

147 recommended or received during the twelve months immediately  
148 preceding the effective date of coverage.

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

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

181 the member's or dependent's initial eligibility.

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

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

200 (g) [A] Notwithstanding the provisions of subsections (b) and (c) of  
201 this section, a short-term health insurance policy issued on a  
202 nonrenewable basis for six months or less which imposes a preexisting  
203 conditions provision shall [not be subject to this section, provided, any  
204 policy, application or sales brochure issued for such short-term  
205 insurance which imposes a preexisting conditions provision shall  
206 disclose that such preexisting conditions are not covered] be subject to  
207 the following conditions: (1) No such preexisting conditions provision  
208 shall exclude coverage beyond twelve months following the insured's  
209 effective date of coverage; (2) such preexisting conditions provision  
210 may only relate to conditions, whether physical or mental, for which  
211 medical advice, diagnosis, care or treatment was recommended or  
212 received during the twenty-four months immediately preceding the  
213 effective date of coverage; and (3) any policy, application or sales

214 brochure issued for such short-term health insurance policy that  
 215 imposes such preexisting conditions provision shall disclose that such  
 216 preexisting conditions are not covered. Nothing in this section shall be  
 217 construed to require a short-term health insurance policy to be issued  
 218 on a guaranteed issue or guaranteed renewable basis. For the purposes  
 219 of this subsection, "nonrenewable basis" means only those policies that  
 220 are issued with a lapse in coverage of more than thirty days between  
 221 an earlier policy and a subsequent policy being issued by the same  
 222 insurer or health care center to the same individual policyholder.

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

226 Sec. 4. Section 38a-816 of the general statutes is amended by adding  
 227 subdivision (23) as follows (*Effective October 1, 2007*):

228 (NEW) (23) Any violation of section 1 of this act."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2007</i>	New section
Sec. 2	<i>October 1, 2007</i>	38a-19
Sec. 3	<i>October 1, 2007</i>	38a-476
Sec. 4	<i>October 1, 2007</i>	38a-816