



General Assembly

January Session, 2007

Amendment

LCO No. 7484

SB0121407484SD0

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 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 shall 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 the insured or such insured's
33 representative knew or should have known 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, or the insured or such insured's
38 representative should have known of such omission, and such
39 omission materially affects the risk or the hazard assumed by the
40 health insurer or health care center. Such decision shall be mailed to
41 the insured, the insured's representative, if any, and the health insurer
42 or health care center.

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

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

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

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 Section 38a-19 of the general statutes is repealed and the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

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

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

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

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

79 Sec. 3. Section 38a-476 of the general statutes is repealed and the

80 following is substituted in lieu thereof (*Effective October 1, 2007*):

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

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

112 (3) "Preexisting conditions provision" means a policy provision

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

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

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

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

143 (2) No individual health insurance plan or insurance arrangement
144 may impose a preexisting conditions provision which excludes

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

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

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

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

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

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

202 (g) [A] Notwithstanding the provisions of subsections (b) and (c) of
203 this section, a short-term health insurance policy issued on a
204 nonrenewable basis for six months or less which imposes a preexisting
205 conditions provision shall [not be subject to this section, provided, any
206 policy, application or sales brochure issued for such short-term
207 insurance which imposes a preexisting conditions provision shall
208 disclose that such preexisting conditions are not covered] be subject to
209 the following conditions: (1) No such preexisting conditions provision
210 shall exclude coverage beyond twelve months following the insured's
211 effective date of coverage; (2) such preexisting conditions provision

212 may only relate to conditions, whether physical or mental, for which
213 medical advice, diagnosis, care or treatment was recommended or
214 received during the twenty-four months immediately preceding the
215 effective date of coverage; and (3) any policy, application or sales
216 brochure issued for such short-term health insurance policy that
217 imposes such preexisting conditions provision shall disclose in a
218 conspicuous manner in not less than fourteen-point bold face type the
219 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 to the same individual, the insurer
227 or health care center shall reduce the preexisting conditions exclusion
228 period in the second policy by the period of time such individual was
229 covered under the first policy. If an insurer or health care center issues
230 a third or subsequent short-term health insurance policy to the same
231 individual, the insurer or health care center shall reduce the
232 preexisting conditions exclusion period in the third or subsequent
233 policy by the cumulative time covered under the prior policies.
234 Nothing in this section shall be construed to require a short-term
235 health insurance policy to be issued on a guaranteed issue or
236 guaranteed renewable basis.

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

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

242 (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