



House of Representatives

General Assembly

File No. 311

February Session, 2008

Substitute House Bill No. 5689

House of Representatives, March 31, 2008

The Committee on Insurance and Real Estate reported through REP. O'CONNOR of the 35th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ALLOWING THE SALE OF GROUP SPECIFIED DISEASE POLICIES.

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

1 Section 1. (NEW) (*Effective January 1, 2009*) (a) As used in this
2 section: (1) "Group specified disease policy" means a group policy
3 delivered, issued for delivery, renewed, amended or continued in this
4 state on or after January 1, 2009, that pays benefits for the diagnosis or
5 treatment of one or more specifically named diseases, illnesses,
6 conditions or syndromes. Such policy may additionally provide
7 benefits for any other condition or disease directly caused or
8 aggravated by the specified disease, illness, condition, syndrome or its
9 treatment; and (2) "preexisting condition" means a condition for which
10 medical advice or treatment was recommended by or received from a
11 physician during the six months preceding the effective date of the
12 coverage of the insured.

13 (b) No insurance company shall deliver or issue for delivery in this

14 state any group specified disease policy that has an anticipated loss
15 ratio of less than sixty-five per cent.

16 (c) Each group specified disease policy delivered or issued for
17 delivery in this state shall meet the minimum benefit standards set
18 forth in subdivision (1), (2) or (3) of this subsection:

19 (1) Coverage of medical expenses incurred by each individual
20 insured under such policy, with a deductible not to exceed one
21 thousand dollars, a coinsurance rate not to exceed twenty-five per cent
22 and an aggregate lifetime benefit of not less than fifty thousand
23 dollars;

24 (2) Per diem indemnification for each individual insured under such
25 policy, with no deductible amount and an aggregate benefit limit of
26 not less than fifty thousand dollars while medically confined, subject
27 to the following minimum benefit standards: (A) A fixed-sum payment
28 of not less than one hundred fifty dollars per day for each day of
29 hospital confinement; (B) a fixed-sum payment of not less than one
30 hundred dollars per day for each day of hospital or nonhospital
31 outpatient surgery, chemotherapy and radiation therapy; and (C) a
32 fixed-sum payment of not less than fifty per cent of the hospital
33 inpatient benefit per day for each day of nursing home care, hospice
34 care or home health care for a minimum of one hundred days; or

35 (3) A fixed-sum payment, upon proof of diagnosis of the specified
36 disease, illness, condition or syndrome, of not less than ten thousand
37 dollars, except that such payment amount may be limited to not less
38 than two thousand five hundred dollars for one or more specified
39 covered diseases, illnesses, conditions or syndromes where coverage
40 under such policy is provided for two or more specified diseases,
41 illnesses, conditions or syndromes. Coverage for a fixed-sum payment
42 for a spouse or dependent of the insured may be made available to the
43 insured, provided the benefit amount offered for such spouse or
44 dependent shall not be less than twenty-five per cent of the benefit
45 amount for the insured. Where coverage is advertised or otherwise
46 represented to offer generic coverage of a specified disease, the same

47 dollar amounts shall be payable regardless of the particular subtype of
48 the disease, unless such subtype is clearly identifiable and the policy
49 clearly differentiates such subtype and its benefits.

50 (d) A group specified disease policy that meets the minimum
51 benefit standard requirements set forth in subdivision (1), (2) or (3) of
52 subsection (c) of this section may be approved for sale in this state with
53 the inclusion of some, but not all, of the benefits otherwise permitted
54 by another type of group specified disease policy. Such policy shall
55 contain a conspicuous disclosure that it is a limited benefit policy that
56 provides benefits of the stated policy type but does not contain the
57 minimum benefits required to be provided by the state for a group
58 specified disease policy of the other policy types. The following terms,
59 as appropriate, shall be used to describe the policy types: "Medical
60 expense reimbursement of a specified disease", "per diem
61 indemnification of a specified disease" or "fixed sum payment for
62 diagnosis of a specified disease".

63 (e) Each group specified disease policy delivered, issued for
64 delivery, renewed, amended or continued in this state on or after
65 January 1, 2009, shall meet the following requirements:

66 (1) If payment is conditioned upon pathological diagnosis of a
67 covered condition, such policy shall also provide that if a pathological
68 diagnosis is medically inappropriate, a clinical diagnosis shall be
69 accepted in lieu thereof;

70 (2) Include a renewal, continuation or nonrenewal provision, to
71 appear on the first page of the policy and be appropriately captioned;

72 (3) Disclose any limitations with respect to preexisting conditions in
73 a separate paragraph labeled "Preexisting Conditions Limitation". No
74 policy shall impose a preexisting conditions provision that excludes
75 coverage beyond twelve months following the insured's effective date
76 of coverage;

77 (4) Contain a prominent statement on the first page of the policy in

78 not less than fourteen-point bold face type as follows: "CAUTION!
79 This is a limited policy. Read it carefully. It only pays benefits for
80 (specified condition) treatment (or diagnosis)". The notice shall also
81 appear on the first page of the certificate of coverage provided to the
82 covered person;

83 (5) Include a thirty-day "free look" period. Notice of the "free look"
84 period shall appear on the face page of the policy and on the first page
85 of the certificate of coverage provided to the insured; and

86 (6) Benefits shall be paid regardless of other coverage.

87 (f) No group specified disease policy shall be delivered or issued for
88 delivery in this state unless an outline of coverage is completed and is
89 delivered with the policy or delivered to the applicant at the time
90 application is made.

91 (g) Any application for a group specified disease policy shall
92 contain a prominent statement above the signature of the applicant
93 that a person who is already covered by Medicaid should not purchase
94 this coverage. Such statement shall be in bold face type or contrasting
95 color.

96 (h) A group specified disease policy may condition payment of
97 benefits upon a covered person receiving medically necessary care or
98 treatment or upon the diagnosis of a condition.

99 (i) The commissioner may adopt regulations, in accordance with
100 chapter 54 of the general statutes, to carry out the purposes of this
101 section.

102 Sec. 2. Subsection (c) of section 38a-505 of the general statutes is
103 repealed and the following is substituted in lieu thereof (*Effective*
104 *January 1, 2009*):

105 (c) The commissioner shall adopt regulations, in accordance with
106 chapter 54, to establish minimum standards for benefits under each of
107 the following categories of coverage in individual policies, other than

108 conversion policies issued pursuant to a contractual conversion
 109 privilege under a group policy: Basic hospital expense coverage, basic
 110 medical-surgical expense coverage, hospital confinement indemnity
 111 coverage, major medical expense coverage, disability income
 112 protection coverage, accident only coverage and specified accident
 113 coverage. Specified disease policies, riders and benefits shall be
 114 prohibited [whether issued] on [a group or] an individual basis, except
 115 as provided in section 38a-457, or as determined by the commissioner
 116 provided the commissioner, prior to permitting any sale of such
 117 policies, adopts regulations in accordance with chapter 54 to establish
 118 minimum standards for benefits in such specified disease policies,
 119 certificates, riders, endorsements and benefits.

120 Sec. 3. Subsection (c) of section 38a-554 of the 2008 supplement to
 121 the general statutes is repealed and the following is substituted in lieu
 122 thereof (*Effective January 1, 2009*):

123 (c) The commissioner shall adopt regulations, in accordance with
 124 chapter 54, concerning coordination of benefits between the plan and
 125 other health insurance plans. No group or individual health insurance
 126 policy shall coordinate benefits or otherwise reduce benefit payments
 127 because a person is covered by, or receives benefits from, a group
 128 specified disease policy delivered, issued for delivery, renewed,
 129 amended or continued in this state.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2009</i>	New section
Sec. 2	<i>January 1, 2009</i>	38a-505(c)
Sec. 3	<i>January 1, 2009</i>	38a-554(c)

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill allows insurers to sell group specified disease policies, and further permits the Department of Insurance (DOI) to adopt regulations related to these policies. These provisions will not result in a fiscal impact to DOI.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis**sHB 5689*****AN ACT ALLOWING THE SALE OF GROUP SPECIFIED DISEASE POLICIES.*****SUMMARY:**

This bill permits insurers to issue group specified disease policies in Connecticut, on and after January 1, 2009, that satisfy the minimum benefit standards, required policy provisions, and other requirements it specifies. It defines “group specified disease policy” as a group policy that pays benefits for the diagnosis or treatment of one or more specifically named diseases, illnesses, conditions, or syndromes. It permits the policy also to provide benefits for other conditions or diseases, or their treatment, that a specifically named disease, illness, condition, or syndrome directly causes or aggravates.

Current law prohibits insurers from issuing group or individual specified disease policies, except as (1) the commissioner allows, if he issues regulations establishing minimum standards for them, or (2) provided for in CGS § 38a-457 (although that statute does not relate to specified disease policies). This bill removes group specified disease policies from the general prohibition, and authorizes the commissioner to adopt regulations on group specified disease policies.

The bill prohibits an insurer from delivering or issuing a group specified disease policy unless it has an anticipated loss ratio of 65% or more. (Loss ratio generally is the ratio of claims incurred to direct premiums earned for the same period, expressed as a percentage.)

The bill requires a group specified disease policy to pay benefits without regard to a person’s other benefit plans. It also prohibits a group or individual health insurance policy from coordinating benefits with or otherwise reducing benefit payments because a person covered

under its terms is covered by or receiving benefits from, a group specified disease policy delivered, issued, renewed, amended, or continued in Connecticut. Thus, under the bill, if both a group specified disease policy and another health insurance policy insure a person and provide coverage for his or her medical treatment, each policy must adjudicate claims and pay benefits without considering what the other policy is paying.

EFFECTIVE DATE: January 1, 2009

MINIMUM BENEFIT STANDARDS

The bill requires that each group specified disease policy delivered or issued in Connecticut be one of three policy types: (1) medical expense reimbursement, (2) per-diem indemnification, or (3) fixed-sum payment. It specifies the minimum benefit standards for each, respectively, as follows:

1. coverage for medical expenses incurred, subject to a deductible up to \$1,000, coinsurance up to 25%, and an aggregate lifetime benefit of at least \$50,000;
2. per-diem indemnification while medically confined, subject to no deductible and an aggregate benefit limit of at least \$50,000, as follows: (a) at least \$150 a day for each day of hospital confinement, (b) at least \$100 a day for each day of outpatient surgery, chemotherapy, and radiation therapy (whether or not received at a hospital), and (c) at least 50% of the hospital inpatient benefit, per day, for each day of nursing home care, hospice care, or home health care, for at least 100 days; or
3. a fixed-sum payment of at least \$10,000 upon proof of diagnosis, except that the fixed-sum payment may be limited to at least \$2,500 for one or more specified covered diseases, illnesses, conditions, or syndromes where coverage under the policy is provided for two or more diseases.

The last of these policy options may include coverage for a fixed-

sum payment for an insured's spouse or dependent of at least 25% of the insured's benefit amount. Where coverage is advertised or otherwise represented to offer generic coverage of a specified disease, the policy must pay the same fixed-sum amounts regardless of the particular disease subtype, unless the subtype is clearly identifiable and the policy clearly differentiates the subtype and its benefits.

LIMITED BENEFIT POLICY

The bill permits a group specified disease policy that meets the above minimum benefit standard requirements for one policy type and some, but not all, the requirements for the other types to be approved for sale in Connecticut.

It requires the policy to contain a conspicuous disclosure that it is a limited benefit policy that provides benefits of the stated policy type, but does not contain the minimum benefits Connecticut law requires for a group specified disease policy of the other policy types. It requires the disclosure to use the following terms, as appropriate, to describe the policy types: "medical expense reimbursement of a specified disease," "per diem indemnification of a specified disease," or "fixed-sum payment for diagnosis of a specified disease."

REQUIRED POLICY PROVISIONS AND DISCLOSURES

The bill requires a group specified disease policy delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2009, to meet the following requirements:

1. if the policy conditions payment upon a person receiving a pathological diagnosis, it must also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead;
2. include a renewal, continuation, or nonrenewal provision on the policy's first page that is appropriately captioned;
3. disclose any limitations on preexisting conditions in a separate paragraph labeled "Preexisting Conditions Limitation;"

4. include a 30-day “free look” provision (a period during which a policyholder may cancel the policy for any reason and receive back any premiums paid) and include it on a coverage certificate’s first page and the policy’s face page;
5. pay benefits regardless of other coverage (e.g., cannot coordinate benefits with other policies); and
6. include on a coverage certificate’s first page and the policy’s first page in at least 14-point bold face type, this notice: CAUTION! This is a limited policy. Read it carefully. It only pays benefits for (specified condition) treatment (or diagnosis).

PREEXISTING CONDITIONS

The bill prohibits group specified disease policies from excluding coverage for preexisting conditions for longer than 12 months after the insured’s coverage under the policy takes effect. It defines “preexisting condition” as a condition for which medical advice or treatment was recommended by or received from a physician during the six months before the insured’s coverage effective date.

BENEFIT PAYMENT CONDITION PERMITTED

The bill permits a group specified disease policy to condition the payment of benefits upon a person receiving (1) medically necessary care or treatment or (2) a diagnosis.

OUTLINE OF COVERAGE REQUIREMENT

The bill prohibits a group specified disease policy from being delivered or issued in Connecticut unless a completed outline of coverage is delivered (1) with the policy or (2) to an applicant when he or she applies for a policy.

APPLICATION FORM REQUIREMENT

The bill requires a group specified disease policy application to contain a prominent statement that a person who is already covered by Medicaid should not purchase the coverage. The statement must be printed (1) in bold face or a contrasting color and (2) above the

applicant's signature line.

BACKGROUND

Coordination of Benefits

An insurance policy's coordination of benefits provision (COB) is designed to avoid duplicate claim payments so that a person's benefits from all coverage sources do not exceed 100% of the person's incurred medical expense. For a person covered under more than one health plan, COB establishes the order, manner, and extent to which the plans will pay claims for benefits covered under each.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 15 Nay 2 (03/13/2008)