



# House of Representatives

General Assembly

**File No. 199**

January Session, 2009

Substitute House Bill No. 6531

*House of Representatives, March 25, 2009*

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## ***AN ACT CLARIFYING POSTCLAIMS UNDERWRITING.***

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

1 Section 1. Section 38a-477b of the general statutes is repealed and  
2 the following is substituted in lieu thereof (*Effective October 1, 2009*):

3 (a) As used in this section:

4 (1) "Cancellation" or "cancel" means the prospective termination of  
5 an insurance policy, contract, evidence of coverage or certificate from a  
6 date certain.

7 (2) "Limitation" or "limit" means the imposition of a restriction or  
8 refusal of coverage in an insurance policy, contract, evidence of  
9 coverage or certificate for an existing medical condition.

10 (3) "Preexisting conditions provision" has the same meaning as  
11 provided in section 38a-476.

12 (4) "Rescission" or "rescind" means the retroactive termination of an  
13 insurance policy, contract, evidence of coverage or certificate to the  
14 date of its inception, by which all premiums already paid by an  
15 insured are refunded to such insured and all claims paid by the insurer  
16 or health care center are recouped from providers to whom payment  
17 was made.

18 [(a)] (b) Unless approval is granted pursuant to subsection [(b)] (d)  
19 of this section, no insurer or health care center [may] shall rescind,  
20 cancel or limit any policy of insurance, contract, evidence of coverage  
21 or certificate [that provides] providing coverage of the type specified  
22 in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469,  
23 and:

24 (1) Having a duration of one year or more, on the basis of written  
25 information submitted on [,] or with or omitted from an insurance  
26 application by the insured if the insurer or health care center failed to  
27 complete medical underwriting and resolve all reasonable medical  
28 questions related to the written information submitted on [,] or with or  
29 omitted from the insurance application before issuing the policy,  
30 contract, evidence of coverage or certificate; or

31 (2) Having a duration of less than one year, on the basis of written  
32 information submitted on or with or omitted from an insurance  
33 application by the insured.

34 (c) No insurer or health care center [may] shall rescind, cancel or  
35 limit any such policy, contract, evidence of coverage or certificate more  
36 than two years after the effective date of the policy, contract, evidence  
37 of coverage or certificate.

38 [(b)] (d) An insurer or health care center shall apply for approval of  
39 such rescission, cancellation or limitation by submitting such written  
40 information to the Insurance Commissioner on an application in such  
41 form as the commissioner prescribes. Such insurer or health care center  
42 shall provide a copy of the application for such approval to the insured  
43 or the insured's representative. Not later than seven business days

44 after receipt of the application for such approval, the insured or the  
45 insured's representative shall have an opportunity to review such  
46 application and respond and submit relevant information to the  
47 commissioner with respect to such application. Not later than fifteen  
48 business days after the submission of information by the insured or the  
49 insured's representative, the commissioner shall issue a written  
50 decision on such application. The commissioner may approve such  
51 rescission, cancellation or limitation if the commissioner finds that (1)  
52 the written information submitted on or with the insurance application  
53 was false at the time such application was made and the insured or  
54 such insured's representative knew or should have known of the  
55 falsity therein, and such submission materially affects the risk or the  
56 hazard assumed by the insurer or health care center, or (2) the  
57 information omitted from the insurance application was knowingly  
58 omitted by the insured or such insured's representative, or the insured  
59 or such insured's representative should have known of such omission,  
60 and such omission materially affects the risk or the hazard assumed by  
61 the insurer or health care center. Such decision shall be mailed to the  
62 insured, the insured's representative, if any, and the insurer or health  
63 care center.

64 (e) An insurer or health care center shall limit any investigation to  
65 determine the existence of a preexisting condition based on a  
66 submitted claim to (1) issues having a direct relationship with the  
67 condition that is the subject of the claim, and (2) the period preceding  
68 the effective date of the policy, contract, evidence of coverage or  
69 certificate permitted to be limited or excluded under the preexisting  
70 conditions provision of such policy, contract, evidence of coverage or  
71 certificate.

72 [(c)] (f) Notwithstanding the provisions of chapter 54, any insurer or  
73 insured aggrieved by any decision by the commissioner under  
74 subsection [(b)] (d) of this section may, [within] not later than thirty  
75 days after notice of the commissioner's decision is mailed to such  
76 insurer and insured, take an appeal therefrom to the superior court for  
77 the judicial district of Hartford, which shall be accompanied by a

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

83 (g) An insurer or health care center that accepts a telephonic  
84 application for individual health insurance coverage shall: (1) Provide  
85 in writing to the applicant, prior to the completion of the application  
86 process, all terms and conditions of the policy or contract, including  
87 the maximum duration of such policy or contract, an accurate  
88 description of any preexisting conditions provisions, the relevant  
89 exclusionary periods pertaining to such preexisting conditions and the  
90 monthly premium; (2) use an interactive voice response system or  
91 similar technology to complete the application; (3) retain for the  
92 duration of the policy or contract plus one year, in a readily retrievable  
93 format, a recording of the applicant agreeing to each term and  
94 condition of the policy or contract; (4) mail the applicant a letter  
95 confirming such applicant's agreement to such terms and conditions,  
96 and include a notice that such applicant shall be bound by such terms  
97 and conditions unless such applicant rescinds such agreement in  
98 writing not later than five business days after receipt of such letter; and  
99 (5) retain a copy of such letter and such rescission, if applicable, for the  
100 duration of the policy or contract plus one year.

101 (h) Any insurance producer or agent who completes or assists in the  
102 completion of an application for insurance shall be liable for any  
103 information knowingly omitted or misrepresented by such producer or  
104 agent in such application. If the insurer or health care center includes  
105 with its request for approval of a rescission, cancellation or limitation  
106 pursuant to subsection (d) of this section a statement that such policy,  
107 contract or certificate would not have been issued had such omission  
108 or misrepresentation been known to the insurer or health care center,  
109 the insured shall be held harmless for any claims arising from a  
110 rescission, cancellation or limitation of a policy, contract, evidence of  
111 coverage or certificate.

112 [(d)] (i) The Insurance Commissioner may adopt regulations, in  
113 accordance with chapter 54, to implement the provisions of this  
114 section.

115 Sec. 2. Section 38a-483 of the general statutes is repealed and the  
116 following is substituted in lieu thereof (*Effective from passage*):

117 (a) (1) Not later than December 31, 2009, the commissioner shall  
118 develop, in consultation with the Office of the Healthcare Advocate  
119 and the Office of the Attorney General, uniform and readable  
120 applications for individual health insurance policies authorized to be  
121 sold in this state and shall make such applications available to each  
122 insurer and health care center doing business in this state. Such  
123 applications shall be utilized by each insurer and health care center  
124 doing business in this state for all individual health insurance policies  
125 written on or after January 1, 2010.

126 (2) The commissioner shall establish a process to allow an insurer or  
127 health care center to request approval to include a limited number of  
128 nonstandard questions on the application set forth in subdivision (1) of  
129 this subsection. Not later than seven days after receipt of such request,  
130 the commissioner shall forward a copy of such request to the Office of  
131 the Healthcare Advocate. Said office shall review such request and  
132 submit a recommendation of approval or rejection to the commissioner  
133 not later than fifteen days after receipt of such copy. The commissioner  
134 shall consider the recommendation of said office and shall promptly  
135 notify the insurer or health care center in writing of the decision to  
136 approve or reject such request. The commissioner shall provide a copy  
137 of the decision to said office.

138 (b) Except as provided in subsection [(c)] (d) of this section, each  
139 individual health insurance policy delivered or issued for delivery to  
140 any person in this state shall contain the provisions specified in this  
141 subsection in the words in which the same appear in this section;  
142 provided the insurer may, at its option, substitute for one or more of  
143 such provisions corresponding provisions of different wording  
144 approved by the commissioner which are in each instance not less

145 favorable in any respect to the insured or the beneficiary. Such  
146 provisions shall be preceded individually by the caption appearing in  
147 this subsection or, at the option of the insurer, by such appropriate  
148 individual or group captions or subcaptions as the commissioner may  
149 approve. Such provisions to be contained in such policy shall be:

150 (1) A provision as follows: "ENTIRE CONTRACT: CHANGES: This  
151 policy, including the endorsements and the attached papers, if any,  
152 constitutes the entire contract of insurance. No change in this policy  
153 shall be valid until approved by an executive officer of the insurer and  
154 unless such approval be endorsed hereon or attached hereto. No agent  
155 has authority to change this policy or to waive any of its provisions."

156 (2) A provision as follows: "TIME LIMIT ON CERTAIN DEFENSES:  
157 This policy shall be incontestable, except for nonpayment of premium,  
158 after it has been in force for two years from its date of issue."

159 (3) A provision as follows: "GRACE PERIOD: A grace period of ...  
160 (insert a number not less than seven for weekly premium policies, ten  
161 for monthly premium policies and thirty-one for all other policies)  
162 days will be granted for the payment of each premium falling due after  
163 the first premium, during which grace period the policy shall continue  
164 in force." A policy which contains a cancellation provision may add, at  
165 the end of the above provision, "subject to the right of the insurer to  
166 cancel in accordance with the cancellation provision hereof." A policy  
167 in which the insurer reserves the right to refuse any renewal may have,  
168 at the beginning of the above provision, "Unless not less than five days  
169 prior to the premium due date the insurer has delivered to the insured  
170 or has mailed to his last address as shown by the records of the insurer  
171 written notice of its intention not to renew this policy beyond the  
172 period for which the premium has been accepted."

173 (4) A provision as follows: "REINSTATEMENT: If any renewal  
174 premium is not paid within the time granted the insured for payment,  
175 a subsequent acceptance of premium by the insurer or by any agent  
176 duly authorized by the insurer to accept such premium, without  
177 requiring in connection therewith an application for reinstatement,

178 shall reinstate the policy; provided, if the insurer or such agent  
179 requires an application for reinstatement and issues a conditional  
180 receipt for the premium tendered, the policy shall be reinstated upon  
181 approval of such application by the insurer or, lacking such approval,  
182 upon the forty-fifth day following the date of such conditional receipt  
183 unless the insurer has previously notified the insured, in writing, of its  
184 disapproval of such application. The reinstated policy shall cover only  
185 loss resulting from such accidental injury as may be sustained after the  
186 date of reinstatement and loss due to such sickness as may begin more  
187 than ten days after such date. In all other respects the insured and  
188 insurer shall have the same rights thereunder as they had under the  
189 policy immediately before the due date of the defaulted premium,  
190 subject to any provisions endorsed hereon or attached hereto in  
191 connection with the reinstatement. Any premium accepted in  
192 connection with a reinstatement shall be applied to a period for which  
193 premium has not been previously paid, but not to any period more  
194 than sixty days prior to the date of reinstatement." The last sentence of  
195 the above provision may be omitted from any policy which the insured  
196 has the right to continue in force subject to its terms by the timely  
197 payment of premiums (1) until at least age fifty or (2), in the case of a  
198 policy issued after age forty-four, for at least five years from its date of  
199 issue.

200 (5) A provision as follows: "NOTICE OF CLAIM: Written notice of  
201 claim must be given to the insurer within twenty days after the  
202 occurrence or commencement of any loss covered by the policy, or as  
203 soon thereafter as is reasonably possible. Notice given by or on behalf  
204 of the insured or the beneficiary to the insurer at ... (insert the location  
205 of such office as the insurer may designate for the purpose), or to any  
206 authorized agent of the insurer, with information sufficient to identify  
207 the insured, shall be deemed notice to the insurer." In a policy  
208 providing a loss-of-time benefit which may be payable for at least two  
209 years, an insurer may, at its option, insert the following between the  
210 first and second sentences of the above provision: "Subject to the  
211 qualifications set forth below, if the insured suffers loss of time on  
212 account of disability for which indemnity may be payable for at least

213 two years, he shall, at least once in every six months after having given  
214 notice of claim, give to the insurer notice of continuance of said  
215 disability, except in the event of legal incapacity. The period of six  
216 months following any filing of proof by the insured or any payment by  
217 the insurer on account of such claim or any denial of liability in whole  
218 or in part by the insurer shall be excluded in applying this provision.  
219 Delay in the giving of such notice shall not impair the insured's right to  
220 any indemnity which would otherwise have accrued during the period  
221 of six months preceding the date on which such notice is actually  
222 given."

223 (6) A provision as follows: "CLAIM FORMS: The insurer, upon  
224 receipt of a notice of claim, shall furnish to the claimant such forms as  
225 are usually furnished by it for filing proofs of loss. If such forms are  
226 not furnished within fifteen days after the giving of such notice, the  
227 claimant shall be deemed to have complied with the requirements of  
228 this policy as to proof of loss, upon submitting, within the time fixed in  
229 the policy for filing proofs of loss, written proof covering the  
230 occurrence, the character and the extent of the loss for which claim is  
231 made."

232 (7) A provision as follows: "PROOFS OF LOSS: Written proof of loss  
233 shall be furnished to the insurer at its said office in case of claim for  
234 loss for which this policy provides any periodic payment contingent  
235 upon continuing loss within ninety days after the termination of the  
236 period for which the insurer is liable and in case of claim for any other  
237 loss within ninety days after the date of such loss. Failure to furnish  
238 such proof within the time required shall not invalidate nor reduce any  
239 claim if it was not reasonably possible to give proof within such time,  
240 provided such proof is furnished as soon as reasonably possible and in  
241 no event, except in the absence of legal capacity, later than one year  
242 from the time proof is otherwise required."

243 (8) A provision as follows: "TIME OF PAYMENT OF CLAIMS:  
244 Indemnities payable under this policy for any loss other than loss for  
245 which this policy provides any periodic payment will be paid

246 immediately upon receipt of due written proof of such loss. Subject to  
247 due written proof of loss, all accrued indemnities for loss for which  
248 this policy provides periodic payment shall be paid .... (insert period  
249 for payment which must not be less frequently than monthly) and any  
250 balance remaining unpaid upon the termination of liability will be  
251 paid immediately upon receipt of due written proof."

252 (9) A provision as follows: "PAYMENT OF CLAIMS: Indemnity for  
253 loss of life will be payable in accordance with the beneficiary  
254 designation and the provisions respecting such payment which may be  
255 prescribed herein and effective at the time of payment. If no such  
256 designation or provision is then effective, such indemnity shall be  
257 payable to the estate of the insured. Any other accrued indemnities  
258 unpaid at the insured's death may, at the option of the insurer, be paid  
259 either to such beneficiary or to such estate. All other indemnities will  
260 be payable to the insured." The following provisions, or either of them,  
261 may be included with the foregoing provision at the option of the  
262 insurer: "If any indemnity of this policy shall be payable to the estate of  
263 the insured, or to an insured or beneficiary who is a minor or  
264 otherwise not competent to give a valid release, the insurer may pay  
265 such indemnity, up to an amount not exceeding \$... (insert an amount  
266 which shall not exceed one thousand dollars), to any relative by blood  
267 or connection by marriage of the insured or beneficiary who is deemed  
268 by the insurer to be equitably entitled thereto. Any payment made by  
269 the insurer in good faith pursuant to this provision shall fully  
270 discharge the insurer to the extent of such payment. Subject to any  
271 written direction of the insured in the application or otherwise, all or a  
272 portion of any indemnities provided by this policy on account of  
273 hospital, nursing, medical or surgical services may, at the insurer's  
274 option and unless the insured requests otherwise in writing not later  
275 than the time of filing proofs of such loss, be paid directly to the  
276 hospital or person rendering such services; but it is not required that  
277 the service be rendered by a particular hospital or person."

278 (10) A provision as follows: "PHYSICAL EXAMINATIONS AND  
279 AUTOPSY: The insurer at its own expense shall have the right and

280 opportunity to examine the person of the insured when and as often as  
281 it may reasonably require during the pendency of a claim hereunder  
282 and to make an autopsy in case of death where it is not forbidden by  
283 law."

284 (11) A provision as follows: "LEGAL ACTIONS: No action at law or  
285 in equity shall be brought to recover on this policy prior to the  
286 expiration of sixty days after written proof of loss has been furnished  
287 in accordance with the requirements of this policy. No such action  
288 shall be brought after the expiration of three years after the time  
289 written proof of loss is required to be furnished."

290 (12) A provision as follows: "CHANGE OF BENEFICIARY: Unless  
291 the insured makes an irrevocable designation of beneficiary, the right  
292 to change of beneficiary is reserved to the insured and the consent of  
293 the beneficiary or beneficiaries shall not be requisite to surrender or  
294 assignment of this policy or to any change of beneficiary or  
295 beneficiaries, or to any other changes in this policy." The first clause of  
296 this provision, relating to the irrevocable designation of beneficiary,  
297 may be omitted at the insurer's option.

298 [(b)] (c) Except as provided in subsection [(c)] (d) of this section, no  
299 such policy delivered or issued for delivery to any person in this state  
300 shall contain provisions respecting the matters set forth below unless  
301 such provisions are in the words in which the same appear in this  
302 section; provided the insurer may, at its option, use in lieu of any such  
303 provision a corresponding provision of different wording approved by  
304 the commissioner which is not less favorable in any respect to the  
305 insured or the beneficiary. Any such provision contained in the policy  
306 shall be preceded individually by the appropriate caption appearing in  
307 this subsection or, at the option of the insurer, by such appropriate  
308 individual or group captions or subcaptions as the commissioner may  
309 approve.

310 (1) A provision as follows: "CHANGE OF OCCUPATION: If the  
311 insured be injured or contract sickness after having changed his  
312 occupation to one classified by the insurer as more hazardous than that

313 stated in his policy or while doing for compensation anything  
314 pertaining to an occupation so classified, the insurer will pay only such  
315 portion of the indemnities provided in this policy as the premium paid  
316 would have purchased at the rates and within the limits fixed by the  
317 insurer for such more hazardous occupation. If the insured changes his  
318 occupation to one classified by the insurer as less hazardous than that  
319 stated in this policy, the insurer, upon receipt of proof of such change  
320 of occupation, will reduce the premium rate accordingly, and will  
321 return the excess pro-rata unearned premium from the date of change  
322 of occupation or from the policy anniversary date immediately  
323 preceding receipt of such proof, whichever is the more recent. In  
324 applying this provision, the classification of occupational risk and the  
325 premium rates shall be such as have been last filed by the insurer prior  
326 to the occurrence of the loss for which the insurer is liable or prior to  
327 date of proof of change in occupation with the state official having  
328 supervision of insurance in the state where the insured resided at the  
329 time this policy was issued; but if such filing was not required, then  
330 the classification of occupational risk and the premium rates shall be  
331 those last made effective by the insurer in such state prior to the  
332 occurrence of the loss or prior to the date of proof of change in  
333 occupation."

334 (2) A provision as follows: "MISSTATEMENT OF AGE: If the age of  
335 the insured has been misstated, all amounts payable under this policy  
336 shall be such as the premium paid would have purchased at the  
337 correct age."

338 (3) A provision in accordance with subparagraph (i) or (ii) of this  
339 subdivision as follows: (i) "OTHER INSURANCE IN THIS INSURER:  
340 If an accident or sickness or accident and sickness policy or policies  
341 previously issued by the insurer to the insured be in force concurrently  
342 herewith, making the aggregate indemnity for .... (insert type of  
343 coverage or coverages) in excess of \$.... (insert maximum limit of  
344 indemnity or for such excess shall be returned to the insured or his  
345 estate"; or, (ii) "OTHER INSURANCE IN THIS INSURER: Insurance  
346 effective at any one time on the insured under a like policy or policies

347 in this insurer is limited to the one such policy elected by the insured,  
348 his beneficiary or his estate, as the case may be, and the insurer will  
349 return all premiums paid for all other such policies."

350 (4) A provision as follows: "INSURANCE WITH OTHER  
351 INSURERS: If there be other valid coverage, not with this insurer,  
352 providing benefits for the same loss on a provision of service basis or  
353 on an expense incurred basis and of which this insurer has not been  
354 given written notice prior to the occurrence or commencement of loss,  
355 the only liability under any expense incurred coverage of this policy  
356 shall be for such proportion of the loss as the amount which would  
357 otherwise have been payable hereunder plus the total of the like  
358 amounts under all such other valid coverages for the same loss of  
359 which this insurer had notice bears to the total like amounts under all  
360 valid coverages for such loss, and for the return of such portion of the  
361 premiums paid as shall exceed the pro-rata portion for the amount so  
362 determined. For the purpose of applying this provision when other  
363 coverage is on a provision of service basis, the "like amount" of such  
364 other coverage shall be taken as the amount which the services  
365 rendered would have cost in the absence of such coverage." If the  
366 foregoing policy provision is included in a policy which also contains  
367 the policy provisions specified in subdivision (5) of this subsection,  
368 there shall be added to the caption of the foregoing provision the  
369 phrase "- EXPENSE INCURRED BENEFITS". The insurer may, at its  
370 option, include in this provision a definition of "other valid coverage",  
371 approved as to form by the commissioner, which definition shall be  
372 limited in subject matter to coverage provided by organizations subject  
373 to regulation by insurance law or by insurance authorities of this or  
374 any other state of the United States or any province of Canada, and by  
375 hospital or medical service organizations, and to any other coverage  
376 the inclusion of which may be approved by the commissioner. In the  
377 absence of such definition, such terms shall not include group  
378 insurance, automobile medical payments insurance, or coverage  
379 provided by hospital or medical service organizations or by union  
380 welfare plans or employer or employee benefit organizations. For the  
381 purpose of applying the foregoing policy provision with respect to any

382 insured, any amount of benefit provided for such insured pursuant to  
383 any compulsory benefit statute, including any workers' compensation  
384 or employer's liability statute, whether provided by a governmental  
385 agency or otherwise, shall in all cases be deemed to be "other valid  
386 coverage" of which the insurer has had notice. In applying the  
387 foregoing policy provision no third party liability coverage shall be  
388 included as "other valid coverage".

389 (5) A provision as follows: "INSURANCE WITH OTHER  
390 INSURERS: If there be other valid coverage, not with this insurer,  
391 providing benefits for the same loss on other than an expense incurred  
392 basis and of which this insurer has not been given written notice prior  
393 to the occurrence or commencement of loss, the only liability for such  
394 benefits under this policy shall be for such proportion of the  
395 indemnities otherwise provided hereunder for such loss as the like  
396 indemnities of which the insurer had notice (including the indemnities  
397 under this policy) bear to the total amount of all like indemnities for  
398 such loss, and for the return of such portion of the premium paid as  
399 shall exceed the pro-rata portion for the indemnities thus determined."  
400 If the foregoing policy provision is included in a policy which also  
401 contains the policy provision specified in subdivision (4) of this  
402 subsection, there shall be added to the caption of the foregoing  
403 provision the phrase "- OTHER BENEFITS". The insurer may, at its  
404 option, include in this provision a definition of "other valid coverage",  
405 approved as to form by the commissioner, which definition shall be  
406 limited in subject matter to coverage provided by organizations subject  
407 to regulation by insurance law or by insurance authorities of this or  
408 any other state of the United States or any province of Canada, and to  
409 any other coverage the inclusion of which may be approved by the  
410 commissioner. In the absence of such definition, such term shall not  
411 include group insurance, or benefits provided by union welfare plans  
412 or by employer or employee benefit organizations. For the purpose of  
413 applying the foregoing policy provision with respect to any insured,  
414 any amount of benefit provided for such insured pursuant to any  
415 compulsory benefit statute including any workers' compensation or  
416 employer's liability statute, whether provided by a governmental

417 agency or otherwise shall in all cases be deemed to be "other valid  
418 coverage" of which the insurer has had notice. In applying the  
419 foregoing policy provision no third party liability coverage shall be  
420 included as "other valid coverage".

421 (6) A provision as follows: "RELATION OF EARNINGS TO  
422 INSURANCE: If the total monthly amount of loss of time benefits  
423 promised for the same loss under all valid loss of time coverage upon  
424 the insured, whether payable on a weekly or monthly basis, shall  
425 exceed the monthly earnings of the insured at the time disability  
426 commenced or his average monthly earnings for the period of two  
427 years immediately preceding a disability for which claim is made,  
428 whichever is the greater, the insurer will be liable only for such  
429 proportionate amount of such benefits under this policy as the amount  
430 of such monthly earnings or such average monthly earnings of the  
431 insured bears to the total amount of monthly benefits for the same loss  
432 under all such coverage upon the insured at the time such disability  
433 commences and for the return of such part of the premiums paid  
434 during such two years as shall exceed the pro-rata amount of the  
435 premiums for the benefits actually paid hereunder; but this shall not  
436 operate to reduce the total monthly amount of benefits payable under  
437 all such coverage upon the insured below the sum of two hundred  
438 dollars or the sum of the monthly benefits specified in such coverages,  
439 whichever is the lesser, nor shall it operate to reduce benefits other  
440 than those payable for loss of time." The foregoing policy provision  
441 may be inserted only in a policy which the insured has the right to  
442 continue in force subject to its terms by the timely payment of  
443 premiums (1) until at least age fifty or (2), in the case of a policy issued  
444 after age forty-four, for at least five years from its date of issue. The  
445 insurer may, at its option, include in this provision a definition of  
446 "valid loss of time coverage", approved as to form by the  
447 commissioner, which definition shall be limited in subject matter to  
448 coverage provided by governmental agencies or by organizations  
449 subject to regulation by insurance law or by insurance authorities of  
450 this or any other state of the United States or any province of Canada,  
451 or to any other coverage the inclusion of which may be approved by

452 the commissioner or any combination of such coverages. In the  
453 absence of such definition such term shall not include any coverage  
454 provided for such insured pursuant to any compulsory benefit statute,  
455 including any workers' compensation or employer's liability statute, or  
456 benefits provided by union welfare plans or by employer or employee  
457 benefit organizations.

458 (7) A provision as follows: "UNPAID PREMIUM: Upon the  
459 payment of a claim under this policy, any premium then due and  
460 unpaid or covered by any note or written order may be deducted  
461 therefrom."

462 (8) A provision as follows: "CANCELLATION: The insurer may  
463 cancel this policy at any time by written notice delivered to the insured  
464 and to any dependents who were listed on the application and any  
465 subsequent revisions thereto, or mailed to their last address as shown  
466 by the records of the insurer, stating when, not less than five days  
467 thereafter, such cancellation shall be effective; and after the policy has  
468 been continued beyond its original term the insured may cancel this  
469 policy at any time by written notice delivered or mailed to the insurer,  
470 effective upon receipt or on such later date as may be specified in such  
471 notice. In the event of cancellation, the insurer will return promptly the  
472 unearned portion of any premium paid. If the insured cancels, the  
473 earned premium shall be computed by the use of the short-rate table  
474 last filed with the state official having supervision of insurance in the  
475 state where the insured resided when the policy was issued. If the  
476 insurer cancels, the earned premium shall be computed pro-rata.  
477 Cancellation shall be without prejudice to any claim originating prior  
478 to the effective date of cancellation."

479 (9) A provision as follows: "CONFORMITY WITH STATE  
480 STATUTES: Any provision of this policy which, on its effective date, is  
481 in conflict with the statutes of the state in which the insured resides on  
482 such date is hereby amended to conform to the minimum  
483 requirements of such statutes."

484 [(c)] (d) If any provision of this section is in whole or in part

485 inapplicable to or inconsistent with the coverage provided by a  
486 particular form of policy, the insurer, with the approval of the  
487 commissioner, shall omit from such policy any inapplicable provision  
488 or part of a provision, and shall modify any inconsistent provision or  
489 part of the provision in such manner as to make the provision as  
490 contained in the policy consistent with the coverage provided by the  
491 policy.

492 ~~[(d)]~~ (e) The provisions specified in subsections ~~[(a) and]~~ (b) and (c)  
493 of this section, or any corresponding provisions which are used in lieu  
494 thereof in accordance with said subsections, shall be printed in the  
495 consecutive order of the provisions in such subsections or, at the  
496 option of the insurer, any such provision may appear as a unit in any  
497 part of the policy, with other provisions to which it may be logically  
498 related, provided the resulting policy shall not be in whole or in part  
499 unintelligible, uncertain, ambiguous, abstruse or likely to mislead a  
500 person to whom the policy is offered, delivered or issued.

501 ~~[(e)]~~ (f) The word "insured", as used in sections 38a-481 to 38a-488,  
502 inclusive, shall not be construed as preventing a person other than the  
503 insured with a proper insurable interest from making application for  
504 and owning a policy covering the insured or from being entitled under  
505 such a policy to any indemnities, benefits and rights provided therein.

506 ~~[(f)]~~ (g) (1) Any policy of a foreign or alien insurer, when delivered  
507 or issued for delivery to any person in this state, may contain any  
508 provision which is not less favorable to the insured or the beneficiary  
509 than the provisions of sections 38a-481 to 38a-488, inclusive, and which  
510 is prescribed or required by the law of the state under which the  
511 insurer is organized.

512 (2) Any policy of a domestic insurer may, when issued for delivery  
513 in any other state or country, contain any provision permitted or  
514 required by the laws of such other state or country.

515 ~~[(g)]~~ (h) The commissioner may make such reasonable rules and  
516 regulations concerning the procedure for the filing or submission of

517 policies subject to sections 38a-481 to 38a-488, inclusive, as are  
518 necessary, proper or advisable to the administration of said sections.  
519 This provision shall not abridge any other authority granted the  
520 commissioner by law.

|   |                        |          |
|---|------------------------|----------|
| This act shall take effect as follows and shall amend the following sections: |                        |          |
| Section 1   | <i>October 1, 2009</i> | 38a-477b |
| Sec. 2  | <i>from passage</i>    | 38a-483  |

**Statement of Legislative Commissioners:**

In sections 1 (b)(1) and 1 (b)(2), "Having" was substituted in lieu of "If such policy, contract or certificate is for" for clarity and consistency with the drafting convention of the general statutes.

**INS**      *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

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**OFA Fiscal Note**

**State Impact:**

| <b>Agency Affected</b> | <b>Fund-Effect</b> | <b>FY 10 \$</b> | <b>FY 11 \$</b> |
|------------------------|--------------------|-----------------|-----------------|
| Insurance Dept.        | IF - Cost          | Potential       | Potential       |

Note: IF=Insurance Fund

**Municipal Impact:** None

**Explanation**

This bill could result in a cost to the Insurance Department (DOI). It requires DOI to pre-approve the rescission, cancellation and limitation of short-term insurance policies, regardless of whether the insurer has completed medical underwriting or not. Existing statute does not require pre-approval for the rescission, cancellation and limitation of short-term insurance policies if the insurer has completed medical underwriting. The provisions of this bill could result in an increase in pre-approval reviews by DOI, thereby increasing staff workload and, to the extent that it requires additional staff, incurring potential Personal Services and Fringe Benefit costs for DOI under the Insurance Fund. It is unknown to what extent pre-approvals of rescission, cancellation and limitations of insurance policies will increase due to the provisions of this bill. DOI completed four pre-approval reviews for the rescission of insurance policies in FY 08.

**The Out Years**

The potential fiscal impact will be on-going to the extent that pre-approvals of rescission, cancellation and limitations of insurance policies increase in the out years due to the provisions of this bill, creating a need for increased staff and related fringe benefits.

**OLR Bill Analysis**

**sHB 6531**

***AN ACT CLARIFYING POSTCLAIMS UNDERWRITING.***

**SUMMARY:**

This bill limits a health insurer's or HMO's claim investigation for the purpose of discovering preexisting conditions to those that directly relate to the condition specified in the claim.

It removes the requirement that, in order to rescind, cancel, or limit coverage in certain circumstances, an insurer or HMO must have conducted a thorough medical underwriting process for a policy, contract, or certificate that is in effect for less than one year. It maintains the requirement for coverage in effect for at least one year.

When an insurance producer helps a person complete an application and the producer knowingly omits or misrepresents information in it, the bill makes the producer liable, and holds the insured person harmless (not liable), for any insurance claims arising from a coverage rescission, cancellation, or limitation resulting from the omission or misrepresentation. This result occurs only if the insurer or HMO states in writing to the insurance commissioner, when it applies to rescind, cancel, or limit coverage as the law requires, that it would not have issued coverage had the omission or misrepresentation been known to it.

The bill requires the commissioner to develop "uniform and readable applications" for individual health insurance by December 31, 2009 and establish a process for an insurer or HMO to request approval for nonstandard applications. It sets requirements for an insurer or HMO that accepts coverage applications over the telephone.

It defines certain terms and makes technical and conforming

changes.

EFFECTIVE DATE: July 1, 2009, except for the application provisions, which are effective upon passage.

### **CLAIM INVESTIGATION**

The bill limits a health insurer's or HMO's claim investigation for the purpose of discovering preexisting conditions to (1) preexisting conditions having a direct relationship to the condition specified in the claim and (2) the period before the coverage effective date permitted under the applicable preexisting conditions provision.

By law, a preexisting conditions provision must relate to physical or mental conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the six months (group policy), 12 months (individual policy), or 24 months (short-term policy) immediately before the coverage effective date. The law prohibits health insurance policies from excluding coverage for preexisting conditions for more than 12 months from the insured's policy effective date.

### **UNDERWRITING REQUIREMENT**

The law prohibits health insurers and HMOs, without the insurance commissioner's approval, from rescinding, canceling, or limiting coverage based on information a person submitted with or omitted from an insurance application if, before issuing the policy, contract, or certificate, the insurer or HMO did not perform a thorough medical underwriting process, including resolving all reasonable medical questions based on the written application. The bill makes this prohibition apply only to a policy, contract, or certificate in effect for at least one year.

For a policy, contract, or certificate in effect for less than one year, the bill prohibits an insurer or HMO, without the commissioner's approval, from rescinding, canceling, or limiting coverage based on information a person submitted with or omitted from an insurance application.

The law allows the commissioner to approve the coverage rescission, cancellation, or limitation if the enrollee, or his or her representative, knew or should have known that information material to the insurer's or HMO's risk assumption was (1) false when included with the application or (2) omitted from the application. By law, an insurer or HMO cannot rescind, cancel, or limit coverage that has been effective for more than two years.

The law applies its rescission, cancellation, and limitation requirements to insurers and HMOs issuing policies or contracts that cover:

1. basic hospital expenses,
2. basic medical-surgical expenses,
3. major medical expenses,
4. accidents,
5. limited benefits, and
6. hospital or medical services.

## **APPLICATION REQUIREMENTS**

### ***Uniform Application***

By December 31, 2009, the bill requires the commissioner, in consultation with the healthcare advocate and attorney general offices, to develop “uniform and readable applications” for individual health insurance policies approved for sale in Connecticut. He must make the applications available to insurers and HMOs doing business in Connecticut. The companies must use them for all individual policies written on or after January 1, 2010, unless the commissioner approves the inclusion of nonstandard questions.

***Nonstandard Application Questions.*** The bill requires the commissioner to establish a process through which an insurer or HMO may request approval to include nonstandard questions on an

application. It specifies that, within seven days from receiving such a request, the commissioner must forward it to the healthcare advocate's office. The advocate's office must review it and recommend approval or rejection to the commissioner within 15 days. The commissioner must consider the recommendation, promptly notify the insurer or HMO in writing of his decision to approve or reject the request, and give a copy of his decision to the advocate's office.

### ***Telephonic Applications***

The bill requires an insurer or HMO that accepts applications over the telephone to:

1. give the applicant, in writing and before the application process is complete, all terms and conditions of the policy or contract, including its maximum duration, an accurate description of preexisting conditions provisions, the exclusionary periods for preexisting conditions, and the monthly premium;
2. use an interactive voice response system or similar technology to complete the application;
3. retain, for the policy or contract duration plus one year and in a readily retrievable format, a recording of the applicant agreeing to each policy or contract term and condition;
4. mail the applicant a letter confirming his or her agreement to the terms and conditions that includes notice of a five-day rescission period; and
5. keep a copy of the letter and any applicable rescission for the policy or contract duration plus one year.

***Rescission Notice.*** The rescission notice must inform the applicant that he or she is bound by the policy or contract terms and conditions unless he or she rescinds his or her agreement to them in writing within five business days after receiving the confirmation letter.

**DEFINITIONS**

The bill defines a coverage rescission, cancellation, and limitation. A “rescission” is the retroactive termination of a policy, contract, evidence of coverage, or certificate to its inception date. As a result, an insurer or HMO refunds all premiums paid and recoups all claim payments made to providers. A “cancellation” is the prospective termination of a policy, contract, evidence of coverage, or certificate. A “limitation” is a coverage restriction or refusal for an existing medical condition.

The bill defines a “preexisting conditions provision” as a policy provision that limits or excludes benefits relating to a condition that was present and for which medical advice, diagnosis, care, or treatment was recommended or received before the coverage effective date. A preexisting condition does not include:

1. routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free, unless evidence of breast cancer is found during or as a result of the follow-up;
2. genetic information, unless there is a diagnosis related to such information; or
3. pregnancy.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 14 Nay 5 (03/10/2009)