



House of Representatives

File No. 885

General Assembly

January Session, 2009

(Reprint of File No. 199)

Substitute House Bill No. 6531
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 1, 2009

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 Section 38a-477b of the general statutes is repealed and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 unilateral termination of an
5 insurance policy, contract, evidence of coverage or certificate.

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

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

11 (4) "Rescission" or "rescind" means the termination of an insurance
12 policy, contract, evidence of coverage or certificate by the insurer or
13 health care center to the date of inception on the basis of (A) such

14 insurer's or health care center's discovery of a preexisting condition
15 pursuant to an investigation conducted in accordance with subsection
16 (e) of this section, or (B) a material misstatement, omission or material
17 misrepresentation of fact on an insurance application by the insured
18 that the insurer or health care center relied upon to its detriment.

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

31 (2) Unless approval is granted pursuant to subsection (d) of this
32 section, no insurer or health care center shall rescind, cancel or limit
33 any policy of insurance, contract, evidence of coverage or certificate
34 providing coverage of the type specified in subdivisions (1), (2), (4), (6),
35 (10), (11) and (12) of section 38a-469, and having a duration of less than
36 one year, including short-term health insurance issued on a
37 nonrenewable basis with a duration of six months or less, on the basis
38 of written information submitted on or with or omitted from an
39 insurance application by the insured.

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

44 [(b)] (d) An insurer or health care center shall apply for approval of
45 such rescission, cancellation or limitation by submitting such written

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

70 (e) When investigating a suspected preexisting condition that was
71 not disclosed by an insured, an insurer or health care center shall limit
72 its investigation based on a submitted claim to (1) issues having a
73 direct relationship to the alleged preexisting condition that is the
74 subject of the claim, and (2) the period preceding the effective date of
75 the policy, contract, evidence of coverage or certificate permitted to be
76 limited or excluded under the preexisting conditions provision of such
77 policy, contract, evidence of coverage or certificate.

78 [(c)] (f) Notwithstanding the provisions of chapter 54, any insurer or
79 insured aggrieved by any decision by the commissioner under

80 subsection [(b)] (d) of this section may, [within] not later than thirty
81 days after notice of the commissioner's decision is mailed to such
82 insurer and insured, take an appeal therefrom to the superior court for
83 the judicial district of Hartford, which shall be accompanied by a
84 citation to the commissioner to appear before said court. Such citation
85 shall be signed by the same authority, and such appeal shall be
86 returnable at the same time and served and returned in the same
87 manner, as is required in case of a summons in a civil action. Said court
88 may grant such relief as may be equitable.

89 (g) An insurer or health care center that accepts a telephonic
90 application for individual health insurance coverage shall: (1) Provide
91 to the applicant, prior to the completion of the application process,
92 disclosure of (A) the maximum duration of such policy or contract, (B)
93 any preexisting conditions provisions and an accurate description of
94 each such provision, (C) the relevant exclusionary periods pertaining
95 to such preexisting conditions, and (D) the amount of the monthly
96 premium; (2) retain for two years after the effective date of the policy
97 or contract, in a readily retrievable format, a recording of the
98 applicant's complete telephonic application process; (3) mail the
99 applicant a letter that contains a copy of such applicant's completed
100 application, which may include confirmation of such applicant's
101 agreement to the maximum duration of such policy or contract, the
102 preexisting conditions provisions specified in such policy or contract
103 and the relevant exclusionary periods pertaining to such preexisting
104 conditions and the monthly premium specified for such policy or
105 contract. Such letter shall include a notice that such applicant shall be
106 bound by such agreement unless such applicant rescinds such
107 agreement in writing not later than ten days after receipt of such letter;
108 and (4) retain a copy of such letter and such rescission, if applicable,
109 for two years after the effective date of the policy or contract. The
110 requirements of this subsection shall not apply to telephonic
111 applications for Medicare supplement policies.

112 (h) Any insurance producer or agent who completes or assists in the
113 completion of an application for insurance and an insured who signs

114 such application or does not object to information submitted on or
115 with or omitted from such application shall be jointly and severally
116 liable for any claims resulting from any information knowingly
117 omitted or misrepresented by such producer or agent in such
118 application.

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2009	38a-477b

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.

OFA Fiscal Note

Agency Affected	Fund-Effect	FY 10 \$	FY 11 \$
Insurance Dept.	IF - Potential Cost	See Below	See Below

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill as amended could result in a potential cost to the Insurance Department (DOI) if it prompts an increase in pre-approval reviews by DOI requiring additional staff, incurring Personal Services and Fringe Benefit costs to the Insurance Fund. DOI is tasked by the bill to pre-approve the rescission, cancellation and limitation of short-term insurance policies, regardless of whether the insurer has completed medical underwriting. Existing statute does not require this if the insurer has completed medical underwriting.

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 polices in FY 08.

House "A" strikes the underlying bill, replacing it with a similar version that does not change the fiscal impact of the original bill.

The Out Years

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

OLR Bill Analysis

sHB 6531 (as amended by House "A")*

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, including short-term health insurance issued on a non-renewable basis with a duration of six months or less, on the basis of written information submitted on, with, or omitted from an insurance application by the insured. It maintains the requirement for coverage in effect for at least one year.

The bill makes (1) an insurance producer or agent who completes or helps to complete an insurance application or does not object to information submitted on, with, or omitted from it and (2) an insured who signs the application jointly and severally liable for any claims that result from any information knowingly omitted or misrepresented by the producer or agent in the application.

The bill establishes certain notice, deadline, and rescission requirements for an insurer or HMO that accepts coverage applications over the telephone for individual health insurance coverage. It specifies that these requirements do not apply to Medicare supplement policies.

It defines certain terms and makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2009

*House Amendment "A" (1) eliminates the requirement that the insurance commissioner develop uniform and readable applications for certain individual health insurance and establish a process for an insurer or HMO to request approval for nonstandard applications, (2) makes the insured and producer and agent jointly and severally liable for omissions and misrepresentations under certain circumstances; and (3) changes certain requirements for telephonic applications.

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 condition 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

Current 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 limits this prohibition to a policy, contract, or certificate in effect for at least one year, including short-term health insurance issued on a non-renewable basis for six months or less.

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.

TELEPHONIC APPLICATIONS

The bill requires an insurer or HMO that accepts applications for its individual health insurance coverage over the phone to disclose to the

applicant, before the application process is completed:

1. the maximum duration of the policy or contract,
2. an accurate description of, and the relevant exclusionary period for, any preexisting condition provisions, and
3. the amount of the monthly premium.

The bill also requires them to keep for two years after the policy's or contract's effective date, in a readily retrievable format, a recording of the applicant's complete telephonic application process.

In addition, the bill requires them to mail the applicant a letter that contains a copy of the completed application and must include a notice that the applicant is bound to the agreement unless he or she rescinds the agreement in writing within 10 days after receiving the letter. The bill specifies that the letter may include confirmation of the applicant's agreement to the policy's or contract's (1) maximum duration, (2) pre-existing condition provisions and exclusionary periods for them, and (3) the monthly premium. The insurer or HMO must keep the letter and rescission for two years after the policy's or contract's effective date.

DEFINITIONS

The bill defines a coverage rescission, cancellation, and limitation.

It defines "rescission" as the termination of an insurance policy, contract, evidence of coverage, or certificate by the insurer or HMO to the date of its inception on the basis of a:

1. the discovery of a preexisting condition pursuant to an investigation conducted in accordance with the bill or
2. a material misstatement, omission, or material misrepresentation of fact on an insurance application by the insured that the insurer or HMO relied upon to its detriment.

A “cancellation” is the unilateral termination of a policy, contract, evidence of coverage, or certificate.

A “limitation” is a coverage restriction or refusal for an existing or preexisting 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.

BACKGROUND

Joint and Several Liability

Joint and several liability is a form of liability used in civil cases where two or more people are found liable for damages. The winning plaintiff in such a case may collect the entire judgment from any one of the parties, or from any and all of the parties in various amounts until the judgment is paid in full. In other words, if any of the defendants do not have enough money or assets to pay an equal share of the award, the other defendants must make up the difference.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 14 Nay 5 (03/10/2009)