



**Substitute House Bill No. 6531**

**Public Act No. 09-135**

**AN ACT CLARIFYING POSTCLAIMS UNDERWRITING.**

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

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 Section 38a-477b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

(a) As used in this section:

(1) "Cancellation" or "cancel" means the unilateral termination of an insurance policy, contract, evidence of coverage or certificate.

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

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

(4) "Rescission" or "rescind" means the termination of an insurance policy, contract, evidence of coverage or certificate by the insurer or health care center to the date of inception on the basis of (A) such insurer's or health care center's discovery of a preexisting condition pursuant to an investigation conducted in accordance with subsection (e) of this section, or (B) a material misstatement, omission or material

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misrepresentation of fact on an insurance application by the insured that the insurer or health care center relied upon to its detriment.

[(a)] (b) (1) Unless approval is granted pursuant to subsection [(b)] (d) of this section, no insurer or health care center [may] shall rescind, cancel or limit any policy of insurance, contract, evidence of coverage or certificate [that provides] providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, and having a duration of one year or more, on the basis of written information submitted on [ ] or with or omitted from an insurance application by the insured if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on [ ] or with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate.

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

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

[(b)] (d) An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such

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form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner may approve such rescission, cancellation or limitation if the commissioner finds that (1) the written information submitted on or with the insurance application was false at the time such application was made and the insured or such insured's representative knew or should have known of the falsity therein, and such submission materially affects the risk or the hazard assumed by the insurer or health care center, or (2) the information omitted from the insurance application was knowingly omitted by the insured or such insured's representative, or the insured or such insured's representative should have known of such omission, and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center.

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

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[(c)] (f) Notwithstanding the provisions of chapter 54, any insurer or insured aggrieved by any decision by the commissioner under subsection [(b)] (d) of this section may, [within] not later than thirty days after notice of the commissioner's decision is mailed to such insurer and insured, take an appeal therefrom to the superior court for the judicial district of Hartford, which shall be accompanied by a citation to the commissioner to appear before said court. Such citation shall be signed by the same authority, and such appeal shall be returnable at the same time and served and returned in the same manner, as is required in case of a summons in a civil action. Said court may grant such relief as may be equitable.

(g) An insurer or health care center that accepts a telephonic application for individual health insurance coverage shall: (1) Provide to the applicant, prior to the completion of the application process, disclosure of (A) the maximum duration of such policy or contract, (B) any preexisting conditions provisions and an accurate description of each such provision, (C) the relevant exclusionary periods pertaining to such preexisting conditions, and (D) the amount of the monthly premium; (2) retain for two years after the effective date of the policy or contract, in a readily retrievable format, a recording of the applicant's complete telephonic application process; (3) mail the applicant a letter that contains a copy of such applicant's completed application, which may include confirmation of such applicant's agreement to the maximum duration of such policy or contract, the preexisting conditions provisions specified in such policy or contract and the relevant exclusionary periods pertaining to such preexisting conditions and the monthly premium specified for such policy or contract. Such letter shall include a notice that such applicant shall be bound by such agreement unless such applicant rescinds such agreement in writing not later than ten days after receipt of such letter; and (4) retain a copy of such letter and such rescission, if applicable, for two years after the effective date of the policy or contract. The

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requirements of this subsection shall not apply to telephonic applications for Medicare supplement policies.

(h) Any insurance producer or agent who completes or assists in the completion of an application for insurance and an insured who signs such application or does not object to information submitted on or with or omitted from such application shall be jointly and severally liable for any claims resulting from any information knowingly omitted or misrepresented by such producer or agent in such application.

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

Vetoed June 22, 2009