



House of Representatives

General Assembly

File No. 56

February Session, 2010

Substitute House Bill No. 5219

House of Representatives, March 16, 2010

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 EXTENDING STATE CONTINUATION OF HEALTH INSURANCE COVERAGE.

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

1 Section 1. Section 38a-538 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective from passage*):

3 Each employer shall allow individuals to elect to continue coverage
4 under a group plan pursuant to [federal extension requirements
5 established by the Consolidated Omnibus Budget Reconciliation Act of
6 1985 (P.L. 99-272), as amended] section 38a-554, as amended by this
7 act.

8 Sec. 2. Section 38a-554 of the 2010 supplement to the general statutes
9 is repealed and the following is substituted in lieu thereof (*Effective*
10 *from passage*):

11 A group comprehensive health care plan shall contain the minimum
12 standard benefits prescribed in section 38a-553 and shall also conform

13 in substance to the requirements of this section.

14 (a) The plan shall be one under which the individuals eligible to be
15 covered include: (1) Each eligible employee; (2) the spouse of each
16 eligible employee, who shall be considered a dependent for the
17 purposes of this section; and (3) unmarried children who are under
18 twenty-six years of age. Each plan shall cover a stepchild on the same
19 basis as a biological child.

20 (b) The plan shall provide the option to continue coverage under
21 each of the following circumstances until the individual is eligible for
22 other group insurance, except as provided in subdivisions (3) and (4)
23 of this subsection:

24 (1) Notwithstanding any provision of this section, upon layoff,
25 reduction of hours, leave of absence [] or termination of employment,
26 other than as a result of death of the employee or as a result of such
27 employee's "gross misconduct" as that term is used in 29 USC 1163(2),
28 continuation of coverage for such employee and such employee's
29 covered dependents for [the periods set forth for such event under
30 federal extension requirements established by the federal Consolidated
31 Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended
32 from time to time] a period of thirty months after the date of such
33 layoff, reduction of hours, leave of absence or termination of
34 employment, except that if such reduction of hours, leave of absence or
35 termination of employment results from an employee's eligibility to
36 receive Social Security income, continuation of coverage for such
37 employee and such employee's covered dependents until midnight of
38 the day preceding such person's eligibility for benefits under Title
39 XVIII of the Social Security Act;

40 (2) [upon] Upon the death of the employee, continuation of
41 coverage for the covered dependents of such employee for the periods
42 set forth for such event under federal extension requirements
43 established by the Consolidated Omnibus Budget Reconciliation Act of
44 1985, P.L. 99-272, as amended from time to time;

45 (3) [regardless] Regardless of the employee's or dependent's
46 eligibility for other group insurance, during an employee's absence
47 due to illness or injury, continuation of coverage for such employee
48 and such employee's covered dependents during continuance of such
49 illness or injury or for up to twelve months from the beginning of such
50 absence;

51 (4) [regardless] Regardless of an individual's eligibility for other
52 group insurance, upon termination of the group plan, coverage for
53 covered individuals who were totally disabled on the date of
54 termination shall be continued without premium payment during the
55 continuance of such disability for a period of twelve calendar months
56 following the calendar month in which the plan was terminated,
57 provided claim is submitted for coverage within one year of the
58 termination of the plan;

59 (5) [the] The coverage of any covered individual shall terminate: (A)
60 As to a child, the plan shall provide the option for said child to
61 continue coverage for the longer of the following periods: (i) At the
62 end of the month following the month in which the child: Marries;
63 ceases to be a resident of the state; becomes covered under a group
64 health plan through the dependent's own employment; or attains the
65 age of twenty-six. The residency requirement shall not apply to
66 dependent children under nineteen years of age or full-time students
67 attending an accredited institution of higher education. If on the date
68 specified for termination of coverage on a child, the child is unmarried
69 and incapable of self-sustaining employment by reason of mental or
70 physical handicap and chiefly dependent upon the employee for
71 support and maintenance, the coverage on such child shall continue
72 while the plan remains in force and the child remains in such
73 condition, provided proof of such handicap is received by the carrier
74 within thirty-one days of the date on which the child's coverage would
75 have terminated in the absence of such incapacity. The carrier may
76 require subsequent proof of the child's continued incapacity and
77 dependency but not more often than once a year thereafter, or (ii) for
78 the periods set forth for such child under federal extension

79 requirements established by the Consolidated Omnibus Budget
80 Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;
81 (B) as to the employee's spouse, at the end of the month following the
82 month in which a divorce, court-ordered annulment or legal
83 separation is obtained, whichever is earlier, except that the plan shall
84 provide the option for said spouse to continue coverage for the periods
85 set forth for such events under federal extension requirements
86 established by the Consolidated Omnibus Budget Reconciliation Act of
87 1985, P.L. 99-272, as amended from time to time; and (C) as to the
88 employee or dependent who is sixty-five years of age or older, as of
89 midnight of the day preceding such person's eligibility for benefits
90 under Title XVIII of the federal Social Security Act;

91 (6) [as] As to any other event listed as a "qualifying event" in 29 USC
92 1163, as amended from time to time, continuation of coverage for such
93 periods set forth for such event in 29 USC 1162, as amended from time
94 to time, provided such plan may require the individual whose
95 coverage is to be continued to pay up to the percentage of the
96 applicable premium as specified for such event in 29 USC 1162, as
97 amended from time to time.

98 Any continuation of coverage required by this section except
99 subdivision (4) or (6) of this subsection may be subject to the
100 requirement, on the part of the individual whose coverage is to be
101 continued, that such individual contribute that portion of the premium
102 the individual would have been required to contribute had the
103 employee remained an active covered employee, except that the
104 individual may be required to pay up to one hundred two per cent of
105 the entire premium at the group rate if coverage is continued in
106 accordance with subdivision (1), (2) or (5) of this subsection. The
107 employer shall not be legally obligated by sections 38a-505, 38a-546
108 and 38a-551 to 38a-559, inclusive, as amended by this act, to pay such
109 premium if not paid timely by the employee.

110 (c) The commissioner shall adopt regulations, in accordance with
111 chapter 54, concerning coordination of benefits between the plan and

112 other health insurance plans. No individual or group health insurance
113 plan shall coordinate benefits or otherwise reduce benefit payments
114 because a person is covered by or receives benefits from a group
115 specified disease policy delivered, issued for delivery, renewed,
116 amended or continued in this state.

117 (d) The plan shall make available to Connecticut residents, in
118 addition to any other conversion privilege available, a conversion
119 privilege under which coverage shall be available immediately upon
120 termination of coverage under the group plan. The terms and benefits
121 offered under the conversion benefits shall be at least equal to the
122 terms and benefits of an individual comprehensive health care plan.

123 (e) (1) The provisions of subdivision (1) of subsection (b) of this
124 section shall apply to any individual for whom such continuation of
125 coverage is in effect or who elects continuation of coverage pursuant to
126 this section, on or after the effective date of this section.

127 (2) Each insurer and health care center that has issued a group
128 health insurance policy subject to sections 38a-546 and 38a-554, as
129 amended by this act, shall, in conjunction with their group
130 policyholders, including employers with fewer than twenty
131 employees, provide notice of the continuation of coverage period
132 specified in subdivision (1) of subsection (b) of this section to such
133 individuals set forth in subdivision (1) of this subsection not later than
134 sixty days after the effective date of this section.

135 Sec. 3. Section 31-51o of the general statutes is repealed and the
136 following is substituted in lieu thereof (*Effective from passage*):

137 (a) Whenever a relocation or closing of a covered establishment
138 occurs, the employer of the covered establishment shall pay in full for
139 the continuation of existing group health insurance, no matter where
140 the group policy was written, issued or delivered, for each affected
141 employee and his dependents, if covered under the group policy, from
142 the date of relocation or closing for a period of one hundred twenty
143 days or until such time as the employee becomes eligible for other

144 group coverage, whichever is the lesser, provided any right of such
145 employee and his dependents to a continuation of coverage, [for up to
146 seventy-eight or one hundred fifty-six weeks, as the case may be,] as
147 required by section 38a-538, as amended by this act, or 38a-554, as
148 amended by this act, shall not be affected by the provisions of this
149 section, and provided further the period of continued coverage
150 required by said sections shall not commence until the period of
151 continued coverage established by this section has terminated.

152 (b) The provisions of this section shall not apply to those employees
153 who, upon the relocation or closing of a covered establishment, choose
154 to continue their employment with the employer at the new location of
155 the facility.

156 (c) Notwithstanding the provisions of this section, any contractual
157 agreement arrived at through a collective bargaining process that
158 contains provisions requiring the employer to pay for the continuation
159 of existing group health insurance for his affected employees in the
160 event of a relocation or closing of a covered establishment shall
161 supersede the requirements of this section and, in the event of a
162 conflict, the contractual provisions shall be deemed to be controlling.

163 Sec. 4. Section 38a-564 of the general statutes is repealed and the
164 following is substituted in lieu thereof (*Effective from passage*):

165 As used in this section, sections 12-201, 12-211, 12-212a and [38a-
166 564] 38a-565 to 38a-572, inclusive, as amended by this act:

167 (1) "Pool" means the Connecticut Small Employer Health
168 Reinsurance Pool, established under section 38a-569.

169 (2) "Board" means the board of directors of the pool.

170 (3) "Eligible employee" means an employee who works on a full-
171 time basis, with a normal work week of thirty or more hours and
172 includes a sole proprietor, a partner of a partnership or an
173 independent contractor, provided such sole proprietor, partner or
174 contractor is included as an employee under a health care plan of a

175 small employer but does not include an employee who works on a
176 part-time, temporary or substitute basis. "Eligible employee" shall
177 include any employee who is not actively at work but is covered under
178 the small employer's health insurance plan pursuant to workers'
179 compensation, continuation of benefits pursuant to [federal extension
180 requirements established by the Consolidated Omnibus Budget
181 Reconciliation Act of 1985 (P.L. 99-272), as amended, (COBRA)] section
182 38a-554, as amended by this act, or other applicable laws. [Such
183 employees shall not be counted as eligible employees for the purposes
184 of subsection (4) of this section.]

185 (4) (A) "Small employer" means any person, firm, corporation,
186 limited liability company, partnership or association actively engaged
187 in business or self-employed for at least three consecutive months
188 who, on at least fifty per cent of its working days during the preceding
189 twelve months, employed no more than fifty eligible employees, the
190 majority of whom were employed within the state of Connecticut.
191 "Small employer" includes a self-employed individual. [In] For the
192 purposes of determining the number of eligible employees [,
193 companies which] under this subdivision: (i) Companies that are
194 affiliated companies, as defined in section 33-840, or [which] that are
195 eligible to file a combined tax return for purposes of taxation under
196 chapter 208 shall be considered one employer; [Eligible employees
197 shall not include] (ii) employees covered through the employer by
198 health insurance plans or insurance arrangements issued to or in
199 accordance with a trust established pursuant to collective bargaining
200 subject to the federal Labor Management Relations Act shall not be
201 counted; and (iii) employees who are not actively at work but are
202 covered under the small employer's health insurance plan pursuant to
203 workers' compensation, continuation of benefits pursuant to section
204 38a-554, as amended by this act, or other applicable laws shall not be
205 counted. Except as otherwise specifically provided, provisions of this
206 section, sections 12-201, 12-211, 12-212a and [38a-564] 38a-565 to 38a-
207 572, inclusive, that apply to a small employer shall continue to apply
208 until the plan anniversary following the date the employer no longer
209 meets the requirements of this definition.

210 (B) "Small employer" does not include (i) a municipality procuring
211 health insurance pursuant to section 5-259, (ii) a private school in this
212 state procuring health insurance through a health insurance plan or an
213 insurance arrangement sponsored by an association of such private
214 schools, (iii) a nonprofit organization procuring health insurance
215 pursuant to section 5-259, unless the Secretary of the Office of Policy
216 and Management and the State Comptroller make a request in writing
217 to the Insurance Commissioner that such nonprofit organization be
218 deemed a small employer for the purposes of this chapter, (iv) an
219 association for personal care assistants procuring health insurance
220 pursuant to section 5-259, or (v) a community action agency procuring
221 health insurance pursuant to section 5-259.

222 (5) "Insurer" means any insurance company, hospital or medical
223 service corporation, or health care center, authorized to transact health
224 insurance business in this state.

225 (6) "Insurance arrangement" means any "multiple employer welfare
226 arrangement", as defined in Section 3 of the Employee Retirement
227 Income Security Act of 1974 (ERISA), as amended from time to time,
228 except for any such arrangement [which] that is fully insured within
229 the meaning of Section 514(b)(6) of said act, as amended from time to
230 time.

231 (7) "Health insurance plan" means any hospital and medical expense
232 incurred policy, hospital or medical service plan contract and health
233 care center subscriber contract and does not include (A) accident only,
234 credit, dental, vision, Medicare supplement, long-term care or
235 disability insurance, hospital indemnity coverage, coverage issued as a
236 supplement to liability insurance, insurance arising out of a workers'
237 compensation or similar law, automobile medical-payments insurance,
238 or insurance under which beneficiaries are payable without regard to
239 fault and which is statutorily required to be contained in any liability
240 insurance policy or equivalent self-insurance, or (B) policies of
241 specified disease or limited benefit health insurance, provided that the
242 carrier offering such policies files on or before March first of each year

243 a certification with the commissioner that contains the following: (i) A
244 statement from the carrier certifying that such policies are being
245 offered and marketed as supplemental health insurance and not as a
246 substitute for hospital or medical expense insurance; (ii) a summary
247 description of each such policy including the average annual premium
248 rates, or range of premium rates in cases where premiums vary by age,
249 gender or other factors, charged for such policies in the state; and (iii)
250 in the case of a policy that is described in this subparagraph and that is
251 offered for the first time in this state on or after October 1, 1993, the
252 carrier files with the commissioner the information and statement
253 required in this subparagraph at least thirty days prior to the date such
254 policy is issued or delivered in this state.

255 (8) "Plan of operation" means the plan of operation of the pool,
256 including articles, bylaws and operating rules, adopted by the board
257 pursuant to section 38a-569.

258 (9) "Late enrollee" means an eligible employee or dependent who
259 requests enrollment in a small employer's health insurance plan
260 following the initial enrollment period provided under the terms of the
261 first plan for which such employee or dependent was eligible through
262 such small employer, provided an eligible employee or dependent
263 shall not be considered a late enrollee if (A) the request for enrollment
264 is made within thirty days after termination of coverage provided
265 under another group health insurance plan and if the individual had
266 not initially requested coverage under such plan solely because he was
267 covered under another group health insurance plan and coverage
268 under that plan has ceased due to termination of employment, death of
269 a spouse, or divorce, or due to that plan's involuntary termination or
270 cancellation by its carrier for reasons other than nonpayment of
271 premium, or (B) the individual is employed by an employer who offers
272 multiple health insurance plans and the individual elects a different
273 health insurance plan during an open enrollment period, or (C) a court
274 has ordered coverage be provided for a spouse or minor child under a
275 covered employee's plan and request for enrollment is made within
276 thirty days after issuance of such court order, or (D) if the request for

277 enrollment is made within thirty days after the marriage of such
278 employee or the birth or adoption of the first child by such employee
279 after the later of the commencement of the employer's plan or the date
280 the pool becomes operational, and satisfactory evidence of such
281 marriage, birth or adoption is provided to the small employer carrier.

282 (10) "Department" means the Insurance Department.

283 (11) "Special health care plan" means a health insurance plan for
284 previously uninsured small employers, established by the board in
285 accordance with section 38a-565 or by the Health Reinsurance
286 Association in accordance with section 38a-570.

287 (12) "Small employer health care plan" means a health insurance
288 plan for small employers, established by the board in accordance with
289 section 38a-568.

290 (13) "Dependent" means the spouse or child of an eligible employee,
291 subject to applicable terms of the health insurance plan covering such
292 employee. [Dependent] "Dependent" shall also include any dependent
293 that is covered under the small employer's health insurance plan
294 pursuant to workers' compensation, continuation of benefits pursuant
295 to [federal extension requirements established by the Consolidated
296 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended,
297 (COBRA)] section 38a-554, as amended by this act, or other applicable
298 laws.

299 (14) "Commissioner" means the Insurance Commissioner.

300 (15) "Member" means each insurer and insurance arrangement
301 participating in the pool.

302 (16) "Small employer carrier" means any insurer or insurance
303 arrangement which offers or maintains group health insurance plans
304 covering eligible employees of one or more small employers.

305 (17) "Preexisting conditions provision" means a policy provision
306 which excludes coverage for charges or expenses incurred during a

307 specified period following the insured's effective date of coverage as to
308 a condition which, during a specified period immediately preceding
309 the effective date of coverage, had manifested itself in such a manner
310 as would cause an ordinary prudent person to seek diagnosis, care or
311 treatment or for which medical advice, diagnosis, care or treatment
312 was recommended or received as to that condition or as to a condition
313 which is pregnancy existing on the effective date of coverage.

314 (18) "Base premium rate" means, as to any health insurance plan or
315 insurance arrangement covering one or more employees of a small
316 employer, the lowest new business premium rate charged by the
317 insurer or insurance arrangement for the same or similar coverage
318 which is equivalent in value under a plan or arrangement covering any
319 small employer with similar case characteristics, other than claim
320 experience, as determined by such insurer or insurance arrangement,
321 except that as to any small employer carrier or insurance arrangement
322 not issuing new health insurance plans or insurance arrangements to a
323 small employer, "base premium rate" means the lowest rate charged a
324 small employer for the same or similar coverage which is equivalent in
325 value, under a plan or arrangement covering any small employer with
326 similar case characteristics, other than claim experience, as determined
327 by such insurer or insurance arrangement.

328 (19) "Low-income eligible employee" means an eligible employee of
329 a small employer whose annualized wages from such small employer
330 determined as of the effective date of the special health care plan or as
331 of any anniversary of such effective date as certified to the insurer or
332 insurance arrangement or the Health Reinsurance Association, as the
333 case may be, by such small employer is less than three hundred per
334 cent of the federal poverty level applicable to such person.

335 (20) "Medicare" means the Health Insurance for the Aged Act, Title
336 XVIII of the Social Security Amendments of 1965, as amended from
337 time to time.

338 (21) "Health Reinsurance Association" means the entity established
339 and maintained in accordance with the provisions of sections 38a-505,

340 38a-546 and 38a-551 to 38a-559, inclusive, as amended by this act.

341 (22) "Reimbursement rate" means, as to individuals covered under
342 special health care plans or an individual special health care plan,
343 seventy-five per cent of the Medicare reimbursement rate for benefits
344 normally reimbursable under Medicare. For services or supplies not
345 reimbursed by Medicare, such reimbursement shall be seventy-five per
346 cent of the amount which would be payable under Medicare, if
347 Medicare was responsible for benefit payments under such plans for
348 such services and supplies, as determined by the board and approved
349 by the commissioner.

350 (23) "Individual special health care plan" means a health insurance
351 plan for individuals, issued by the Health Reinsurance Association in
352 accordance with section 38a-571 or issued by an insurer in accordance
353 with section 38a-565.

354 (24) "Low-income individual" means an individual whose adjusted
355 gross income (AGI) for the individual and spouse, from the most
356 recent federal tax return filed prior to the date of application for the
357 individual special health care plan or prior to any anniversary of the
358 effective date of the plan, as certified by such individual, is less than
359 three hundred per cent of the applicable federal poverty level.

360 (25) "Medicare reimbursement rate" means the amount which
361 would be payable under Medicare for benefits normally reimbursed
362 under Medicare.

363 (26) "Health care center" means health care center as defined in
364 section 38a-175.

365 (27) "Case characteristics" means demographic or other objective
366 characteristics of a small employer, including age, sex, family
367 composition, location, size of group, administrative cost savings
368 resulting from the administration of an association group plan or a
369 plan written pursuant to section 5-259 and industry classification, as
370 determined by a small employer carrier, that are considered by the

371 small employer carrier in the determination of premium rates for the
372 small employer. Claim experience, health status, and duration of
373 coverage since issue are not case characteristics for the purpose of
374 sections 38a-564 to 38a-572, inclusive, as amended by this act.

375 (28) "Actuarial certification" means a written statement by a member
376 of the American Academy of Actuaries or other individual acceptable
377 to the commissioner that a small employer carrier is in compliance
378 with the provisions of subdivisions (4), (6), (7) and (9) of section 38a-
379 567 and the regulations promulgated by the commissioner pursuant to
380 [subdivision (8) of] section 38a-567, as amended by this act, based
381 upon the person's examination, including a review of the appropriate
382 records and of the actuarial assumptions and methods used by the
383 small employer carrier in establishing premium rates for applicable
384 health benefit plans.

385 Sec. 5. Section 38a-567 of the general statutes is repealed and the
386 following is substituted in lieu thereof (*Effective from passage*):

387 Health insurance plans and insurance arrangements covering small
388 employers and insurers and producers marketing such plans and
389 arrangements shall be subject to the following provisions:

390 (1) (A) Any such plan or arrangement shall be renewable with
391 respect to all eligible employees or dependents at the option of the
392 small employer, policyholder or contractholder, as the case may be,
393 except: (i) For nonpayment of the required premiums by the small
394 employer, policyholder or contractholder; (ii) for fraud or
395 misrepresentation of the small employer, policyholder or
396 contractholder or, with respect to coverage of individual insured, the
397 insureds or their representatives; (iii) for noncompliance with plan or
398 arrangement provisions; (iv) when the number of insureds covered
399 under the plan or arrangement is less than the number of insureds or
400 percentage of insureds required by participation requirements under
401 the plan or arrangement; or (v) when the small employer, policyholder
402 or contractholder is no longer actively engaged in the business in
403 which it was engaged on the effective date of the plan or arrangement.

404 (B) Renewability of coverage may be effected by either continuing in
405 effect a plan or arrangement covering a small employer or by
406 substituting upon renewal for the prior plan or arrangement the plan
407 or arrangement then offered by the carrier that most closely
408 corresponds to the prior plan or arrangement and is available to other
409 small employers. Such substitution shall only be made under
410 conditions approved by the commissioner. A carrier may substitute a
411 plan or arrangement as stated above only if the carrier effects the same
412 substitution upon renewal for all small employers previously covered
413 under the particular plan or arrangement, unless otherwise approved
414 by the commissioner. The substitute plan or arrangement shall be
415 subject to the rating restrictions specified in this section on the same
416 basis as if no substitution had occurred, except for an adjustment
417 based on coverage differences.

418 (C) Notwithstanding the provisions of this subdivision, any such
419 plan or arrangement, or any coverage provided under such plan or
420 arrangement may be rescinded for fraud, material misrepresentation
421 or concealment by an applicant, employee, dependent or small
422 employer.

423 (D) Any individual who was not a late enrollee at the time of his or
424 her enrollment and whose coverage is subsequently rescinded shall be
425 allowed to reenroll as of a current date in such plan or arrangement
426 subject to any preexisting condition or other provisions applicable to
427 new enrollees without previous coverage. On and after the effective
428 date of such individual's reenrollment, the small employer carrier may
429 modify the premium rates charged to the small employer for the
430 balance of the current rating period and for future rating periods, to
431 the level determined by the carrier as applicable under the carrier's
432 established rating practices had full, accurate and timely underwriting
433 information been supplied when such individual initially enrolled in
434 the plan. The increase in premium rates allowed by this provision for
435 the balance of the current rating period shall not exceed twenty-five
436 per cent of the small employer's current premium rates. Any such
437 increase for the balance of said current rating period shall not be

438 subject to the rate limitation specified in subdivision (6) of this section.
439 The rate limitation specified in this section shall otherwise be fully
440 applicable for the current and future rating periods. The modification
441 of premium rates allowed by this subdivision shall cease to be
442 permitted for all plans and arrangements on the first rating period
443 commencing on or after July 1, 1995.

444 (2) Except in the case of a late enrollee who has failed to provide
445 evidence of insurability satisfactory to the insurer, the plan or
446 arrangement may not exclude any eligible employee or dependent
447 who would otherwise be covered under such plan or arrangement on
448 the basis of an actual or expected health condition of such person. No
449 plan or arrangement may exclude an eligible employee or eligible
450 dependent who, on the day prior to the initial effective date of the plan
451 or arrangement, was covered under the small employer's prior health
452 insurance plan or arrangement pursuant to workers' compensation,
453 continuation of benefits pursuant to [federal extension requirements
454 established by the Consolidated Omnibus Budget Reconciliation Act of
455 1985 (P.L. 99-2721, as amended)] section 38a-554, as amended by this
456 act, or other applicable laws. The employee or dependent must request
457 coverage under the new plan or arrangement on a timely basis and
458 such coverage shall terminate in accordance with the provisions of the
459 applicable law.

460 (3) (A) For rating periods commencing on or after October 1, 1993,
461 and prior to July 1, 1994, the premium rates charged or offered for a
462 rating period for all plans and arrangements may not exceed one
463 hundred thirty-five per cent of the base premium rate for all plans or
464 arrangements.

465 (B) For rating periods commencing on or after July 1, 1994, and prior
466 to July 1, 1995, the premium rates charged or offered for a rating
467 period for all plans or arrangements may not exceed one hundred
468 twenty per cent of the base premium rate for such rating period. The
469 provisions of this subdivision shall not apply to any small employer
470 who employs more than twenty-five eligible employees.

471 (4) For rating periods commencing on or after October 1, 1993, and
472 prior to July 1, 1995, the percentage increase in the premium rate
473 charged to a small employer, who employs not more than twenty-five
474 eligible employees, for a new rating period may not exceed the sum of:

475 (A) The percentage change in the base premium rate measured from
476 the first day of the prior rating period to the first day of the new rating
477 period;

478 (B) An adjustment of the small employer's premium rates for the
479 prior rating period, and adjusted pro rata for rating periods of less
480 than one year, due to the claim experience, health status or duration of
481 coverage of the employees or dependents of the small employer, such
482 adjustment (i) not to exceed ten per cent annually for the rating
483 periods commencing on or after October 1, 1993, and prior to July 1,
484 1994, and (ii) not to exceed five per cent annually for the rating periods
485 commencing on or after July 1, 1994, and prior to July 1, 1995; and

486 (C) Any adjustments due to change in coverage or change in the
487 case characteristics of the small employer, as determined from the
488 small employer carrier's applicable rate manual.

489 (5) (A) With respect to plans or arrangements issued on or after July
490 1, 1995, the premium rates charged or offered to small employers shall
491 be established on the basis of a community rate, adjusted to reflect one
492 or more of the following classifications:

493 (i) Age, provided age brackets of less than five years shall not be
494 utilized;

495 (ii) Gender;

496 (iii) Geographic area, provided an area smaller than a county shall
497 not be utilized;

498 (iv) Industry, provided the rate factor associated with any industry
499 classification shall not vary from the arithmetic average of the highest
500 and lowest rate factors associated with all industry classifications by

501 greater than fifteen per cent of such average, and provided further, the
502 rate factors associated with any industry shall not be increased by
503 more than five per cent per year;

504 (v) Group size, provided the highest rate factor associated with
505 group size shall not vary from the lowest rate factor associated with
506 group size by a ratio of greater than 1.25 to 1.0;

507 (vi) Administrative cost savings resulting from the administration of
508 an association group plan or a plan written pursuant to section 5-259,
509 provided the savings reflect a reduction to the small employer carrier's
510 overall retention that is measurable and specifically realized on items
511 such as marketing, billing or claims paying functions taken on directly
512 by the plan administrator or association, except that such savings may
513 not reflect a reduction realized on commissions;

514 (vii) Savings resulting from a reduction in the profit of a carrier who
515 writes small business plans or arrangements for an association group
516 plan or a plan written pursuant to section 5-259 provided any loss in
517 overall revenue due to a reduction in profit is not shifted to other small
518 employers; and

519 (viii) Family composition, provided the small employer carrier shall
520 utilize only one or more of the following billing classifications: (I)
521 Employee; (II) employee plus family; (III) employee and spouse; (IV)
522 employee and child; (V) employee plus one dependent; and (VI)
523 employee plus two or more dependents.

524 (B) The small employer carrier shall quote premium rates to small
525 employers after receipt of all demographic rating classifications of the
526 small employer group. No small employer carrier may inquire
527 regarding health status or claims experience of the small employer or
528 its employees or dependents prior to the quoting of a premium rate.

529 (C) The provisions of subparagraphs (A) and (B) of this subdivision
530 shall apply to plans or arrangements issued on or after July 1, 1995.
531 The provisions of subparagraphs (A) and (B) of this subdivision shall

532 apply to plans or arrangements issued prior to July 1, 1995, as of the
533 date of the first rating period commencing on or after that date, but no
534 later than July 1, 1996.

535 (6) For any small employer plan or arrangement on which the
536 premium rates for employee and dependent coverage or both, vary
537 among employees, such variations shall be based solely on age and
538 other demographic factors permitted under subparagraph (A) of
539 subdivision (5) of this section and such variations may not be based on
540 health status, claim experience, or duration of coverage of specific
541 enrollees. Except as otherwise provided in subdivision (1) of this
542 section, any adjustment in premium rates charged for a small
543 employer plan or arrangement to reflect changes in case characteristics
544 prior to the end of a rating period shall not include any adjustment to
545 reflect the health status, medical history or medical underwriting
546 classification of any new enrollee for whom coverage begins during
547 the rating period.

548 (7) For rating periods commencing prior to July 1, 1995, in any case
549 where a small employer carrier utilized industry classification as a case
550 characteristic in establishing premium rates, the rate factor associated
551 with any industry classification shall not vary from the arithmetical
552 average of the highest and lowest rate factors associated with all
553 industry classifications by greater than fifteen per cent of such average.

554 (8) Differences in base premium rates charged for health benefit
555 plans by a small employer carrier shall be reasonable and reflect
556 objective differences in plan design, not including differences due to
557 the nature of the groups assumed to select particular health benefit
558 plans.

559 (9) For rating periods commencing prior to July 1, 1995, in any case
560 where an insurer issues or offers a policy or contract under which
561 premium rates for a specific small employer are established or
562 adjusted in part based upon the actual or expected variation in claim
563 costs or actual or expected variation in health conditions of the
564 employees or dependents of such small employer, the insurer shall

565 make reasonable disclosure of such rating practices in solicitation and
566 sales materials utilized with respect to such policy or contract.

567 (10) If a small employer carrier denies coverage as requested to a
568 small employer that is self-employed, the small employer carrier shall
569 promptly offer such small employer the opportunity to purchase a
570 small employer health care plan. If a small employer carrier or any
571 producer representing that carrier fails, for any reason, to offer
572 coverage as requested by a small employer that is self-employed, that
573 small employer carrier shall promptly offer such small employer an
574 opportunity to purchase a small employer health care plan.

575 (11) No small employer carrier or producer shall, directly or
576 indirectly, engage in the following activities:

577 (A) Encouraging or directing small employers to refrain from filing
578 an application for coverage with the small employer carrier because of
579 the health status, claims experience, industry, occupation or
580 geographic location of the small employer, except the provisions of
581 this subparagraph shall not apply to information provided by a small
582 employer carrier or producer to a small employer regarding the
583 carrier's established geographic service area or a restricted network
584 provision of a small employer carrier; or

585 (B) Encouraging or directing small employers to seek coverage from
586 another carrier because of the health status, claims experience,
587 industry, occupation or geographic location of the small employer.

588 (12) No small employer carrier shall, directly or indirectly, enter into
589 any contract, agreement or arrangement with a producer that provides
590 for or results in the compensation paid to a producer for the sale of a
591 health benefit plan to be varied because of the health status, claims
592 experience, industry, occupation or geographic area of the small
593 employer. A small employer carrier shall provide reasonable
594 compensation, as provided under the plan of operation of the
595 program, to a producer, if any, for the sale of a special or a small
596 employer health care plan. No small employer carrier shall terminate,

597 fail to renew or limit its contract or agreement of representation with a
598 producer for any reason related to the health status, claims experience,
599 occupation, or geographic location of the small employers placed by
600 the producer with the small employer carrier.

601 (13) No small employer carrier or producer shall induce or
602 otherwise encourage a small employer to separate or otherwise
603 exclude an employee from health coverage or benefits provided in
604 connection with the employee's employment.

605 (14) Denial by a small employer carrier of an application for
606 coverage from a small employer shall be in writing and shall state the
607 reasons for the denial.

608 (15) No small employer carrier or producer shall disclose (A) to a
609 small employer the fact that any or all of the eligible employees of such
610 small employer have been or will be reinsured with the pool, or (B) to
611 any eligible employee or dependent the fact that he has been or will be
612 reinsured with the pool.

613 (16) If a small employer carrier enters into a contract, agreement or
614 other arrangement with another party to provide administrative,
615 marketing or other services related to the offering of health benefit
616 plans to small employers in this state, the other party shall be subject
617 to the provisions of this section.

618 (17) The commissioner may adopt regulations in accordance with
619 the provisions of chapter 54 setting forth additional standards to
620 provide for the fair marketing and broad availability of health benefit
621 plans to small employers.

622 (18) Each small employer carrier shall maintain at its principal place
623 of business a complete and detailed description of its rating practices
624 and renewal underwriting practices, including information and
625 documentation that demonstrates that its rating methods and practices
626 are based upon commonly accepted actuarial assumptions and are in
627 accordance with sound actuarial principles. Each small employer

628 carrier shall file with the commissioner annually, on or before March
629 fifteenth, an actuarial certification certifying that the carrier is in
630 compliance with this part and that the rating methods have been
631 derived using recognized actuarial principles consistent with the
632 provisions of sections 38a-564 to 38a-573, inclusive, as amended by this
633 act. Such certification shall be in a form and manner and shall contain
634 such information, as determined by the commissioner. A copy of the
635 certification shall be retained by the small employer carrier at its
636 principle place of business. Any information and documentation
637 described in this subdivision but not subject to the filing requirement
638 shall be made available to the commissioner upon his request. Except
639 in cases of violations of sections 38a-564 to 38a-573, inclusive, as
640 amended by this act, the information shall be considered proprietary
641 and trade secret information and shall not be subject to disclosure by
642 the commissioner to persons outside of the department except as
643 agreed to by the small employer carrier or as ordered by a court of
644 competent jurisdiction.

645 (19) The commissioner may suspend all or any part of this section
646 relating to the premium rates applicable to one or more small
647 employers for one or more rating periods upon a filing by the small
648 employer carrier and a finding by the commissioner that either the
649 suspension is reasonable in light of the financial condition of the
650 carrier or that the suspension would enhance the efficiency and
651 fairness of the marketplace for small employer health insurance.

652 (20) For rating periods commencing prior to July 1, 1995, a small
653 employer carrier shall quote premium rates to any small employer
654 within thirty days after receipt by the carrier of such employer's
655 completed application.

656 (21) Any violation of subdivisions (10) to (16), inclusive, of this
657 section and of any regulations established under subdivision (17) of
658 this section shall be an unfair and prohibited practice under sections
659 38a-815 to 38a-830, inclusive.

660 (22) (A) With respect to plans or arrangements issued pursuant to

661 subsection (i) of section 5-259, at the option of the Comptroller, the
662 premium rates charged or offered to small employers purchasing
663 health insurance shall not be subject to this section, provided (i) the
664 plan or plans offered or issued cover such small employers as a single
665 entity and cover not less than three thousand employees on the date
666 issued, (ii) each small employer is charged or offered the same
667 premium rate with respect to each employee and dependent, and (iii)
668 the plan or plans are written on a guaranteed issue basis.

669 (B) With respect to plans or arrangements issued by an association
670 group plan, at the option of the administrator of the association group
671 plan, the premium rates charged or offered to small employers
672 purchasing health insurance shall not be subject to this section,
673 provided (i) the plan or plans offered or issued cover such small
674 employers as a single entity and cover not less than three thousand
675 employees on the date issued, (ii) each small employer is charged or
676 offered the same premium rate with respect to each employee and
677 dependent, and (iii) the plan or plans are written on a guaranteed issue
678 basis. In addition, such association group (I) shall be a bona fide group
679 as set forth in the Employee Retirement and Security Act of 1974, (II)
680 shall not be formed for the purposes of fictitious grouping, as defined
681 in section 38a-827, and (III) shall not issue any plan that shall cause
682 undue disruption in the insurance marketplace, as determined by the
683 commissioner.

684 Sec. 6. Section 17b-284 of the general statutes is repealed and the
685 following is substituted in lieu thereof (*Effective from passage*):

686 (a) The Commissioner of Social Services may continue, within
687 available appropriations, to provide Medicaid to employed persons
688 who have conditions which prevent them from obtaining health
689 insurance under an employer's group health insurance plan and who
690 would otherwise be eligible for such medical assistance.

691 (b) The commissioner may pay under the Medicaid program, within
692 available appropriations, the employee's share of health insurance
693 under an employer's group health insurance plan for employees who

694 would otherwise be eligible for medical assistance.

695 (c) The commissioner may pay under the Medicaid program, within
696 available appropriations, the premiums for continued health insurance
697 coverage under an employer's group health insurance plan, pursuant
698 to [the federal Consolidated Omnibus Budget Reconciliation Act of
699 1985, as amended] section 38a-554, as amended by this act, for
700 chronically ill and disabled persons who are no longer employed and
701 would otherwise be eligible for Medicaid.

702 Sec. 7. Section 17b-299 of the general statutes is repealed and the
703 following is substituted in lieu thereof (*Effective from passage*):

704 (a) The commissioner or, at the commissioner's discretion, the single
705 point of entry servicer shall review applications for eligibility to
706 determine whether applicants or employers of applicants have
707 discontinued employer-sponsored dependent coverage for the purpose
708 of participation in the HUSKY Plan, Part B.

709 (b) An application may be disapproved if it is determined that a
710 child to be covered under the HUSKY Plan, Part B was covered by an
711 employer-sponsored insurance within the last two months. If the
712 commissioner determines that the time period specified in this
713 subsection is insufficient to effectively deter applicants or employers of
714 applicants from discontinuing employer-sponsored dependent
715 coverage for the purpose of participation in the HUSKY Plan, Part B,
716 the commissioner may extend such period for a maximum of an
717 additional two months.

718 (c) An application may be approved in cases where prior employer-
719 sponsored coverage ended less than two months prior to the
720 determination of eligibility for reasons unrelated to the availability of
721 the HUSKY Plan, Part B, including, but not limited to:

722 (1) Loss of employment due to factors other than voluntary
723 termination;

724 (2) Death of a parent;

725 (3) Change to a new employer that does not provide an option for
726 dependent coverage;

727 (4) Change of address so that no employer-sponsored coverage is
728 available;

729 (5) Discontinuation of health benefits to all employees of the
730 applicant's employer;

731 (6) Expiration of the continuation of coverage periods [established
732 by the Consolidated Omnibus Budget Reconciliation Act of 1985, (P.L.
733 99-272) as amended from time to time, (COBRA)] set forth in sections
734 38a-554, as amended by this act;

735 (7) Self-employment;

736 (8) Termination of health benefits due to a long-term disability;

737 (9) Termination of dependent coverage due to an extreme economic
738 hardship on the part of either the employee or the employer, as
739 determined by the commissioner; or

740 (10) Substantial reduction in either lifetime medical benefits or
741 benefit category available to an employee and dependents under an
742 employer's health care plan.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	38a-538
Sec. 2	<i>from passage</i>	38a-554
Sec. 3	<i>from passage</i>	31-51o
Sec. 4	<i>from passage</i>	38a-564
Sec. 5	<i>from passage</i>	38a-567
Sec. 6	<i>from passage</i>	17b-284
Sec. 7	<i>from passage</i>	17b-299

Statement of Legislative Commissioners:

In section 2(e)(2), "of the continuation of coverage period specified in subdivision (1) of subsection (b) of this section" was inserted after "notice" for clarity.

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.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill, which extends the time in which a beneficiary may participate in their group health insurance policy under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), does not result in a fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis**sHB 5219*****AN ACT EXTENDING STATE CONTINUATION OF HEALTH INSURANCE COVERAGE.*****SUMMARY:**

This bill extends the period for which certain people and their dependents may continue group health insurance under the state's "mini-COBRA" (see BACKGROUND) law from 18 to 30 months. To qualify for the continued coverage, the person must have experienced a specified qualifying event, including a layoff, reduced hours, leave of absence, or termination of employment for other than death or gross misconduct.

The bill's extended coverage provision applies to people who are already continuing coverage due to those qualifying events and people who elect to do so on and after the bill's passage. By law, unchanged by the bill, spouses and dependents who are continuing coverage for any other reason (e.g., death of employee or divorce) are permitted to continue coverage for the period set forth under federal COBRA (i.e., 36 months).

The bill requires each insurer and health care center (i.e., HMO) that has issued a group health insurance policy subject to the continuation requirements, in conjunction with their group policyholders, to provide notice of the extended coverage period to affected people within 60 days of the bill's passage. Group policyholders include those with fewer than 20 employees.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: Upon passage

BACKGROUND

COBRA and Mini-COBRA

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) and state “mini-COBRA” provide certain former employees, retirees, spouses, and children with the right to temporarily continue coverage under an employer’s group health plan after their coverage would otherwise end, so long as the covered person pays the required premiums. A person may be required to pay the full premium and administrative costs, up to 102% of the full group rate premium. Federal COBRA applies to employer groups with 20 or more employees. Connecticut law applies to all groups regardless of size (CGS §§ 38a-538, 546, and 554). The federal government currently offers a 65% subsidy to certain people who have recently lost employment.

Federal COBRA establishes the time period for which coverage must continue for a qualified person, but a plan or state may provide longer periods. Federal COBRA requires coverage to extend for 18 months when a person would otherwise lose coverage because of job loss or reduced work hours. Other qualifying events, or a second qualifying event during the initial period of coverage, may extend coverage up to 36 months. Longer periods may be available for a disabled person.

The duration of coverage under current state law is the same as under COBRA. In addition, state law permits an employee and covered dependents to continue coverage until midnight of the day preceding the employee’s eligibility for Medicare if the employee’s reduced hours, leave of absence, or termination of employment results from his or her eligibility for Social Security income.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/02/2010)