



# Senate

General Assembly

**File No. 1**

February Session, 2010

Senate Bill No. 12

*Senate, March 3, 2010*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the 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 Section 38a-477b of the general statutes is repealed and  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, 2010*):

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),  
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, 2010	38a-477b

**INS**      *Joint Favorable*

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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:*** None

***Municipal Impact:*** None

### ***Explanation***

The bill clarifies PA 07-113, "AAC Postclaims Underwriting," which requires the Department of Insurance (DOI) to provide prior approval or denial of the rescission, cancelation or limitation of individual health insurance policies. Less than 1% (34) of the 35,237 such policies written in 2009 were rescinded without prior department approval. There is no fiscal impact to DOI to approve/deny the rescission, cancelation or limitation of these policies.

### ***The Out Years***

***State Impact:*** None

***Municipal Impact:*** None

*Sources: 2/11/10 Public Hearing Testimony*

**OLR Bill Analysis  
SB 12*****AN ACT CLARIFYING POSTCLAIMS UNDERWRITING.*****SUMMARY:**

This bill limits a health insurer's or HMO's investigation of a claimant's suspected undisclosed preexisting condition. It also makes an (1) insurance producer or agent who completes or helps to complete an insurance application and (2) insured who signs the application or does not object to information submitted on, with, or omitted from it, jointly and severally liable for claims that result from any information the producer or agent knowingly omitted or misrepresented.

The bill also makes a change in laws relating to rescissions and cancellations. By law, in order to rescind, cancel, or limit an insured's coverage, an insurer or HMO must have the insurance commissioner's approval. Current law requires an insurer or HMO also to have conducted a thorough medical underwriting process based on information the insured submitted on, with, or omitted from, an insurance application. The bill maintains this underwriting requirement for coverage that has been in effect for at least one year. But it removes it for coverage that has been in effect for less than one year, including short-term health insurance issued on a non-renewable basis for six months or less. (By law, an insurer or HMO cannot rescind, cancel, or limit any coverage that has been in effect for more than two years.)

Current law applies to insurers and HMOs issuing policies or contracts that cover (1) basic hospital, medical-surgical, or major medical expenses; (2) accidents; (3) limited benefits; or (4) hospital or medical services. The bill exempts accident-only policies from its requirements.

The bill establishes certain disclosure, records, and rescission

requirements for an insurer or HMO that accepts coverage applications for individual health insurance coverage over the telephone. It specifies that these requirements do not apply to Medicare supplement policies.

The insurance commissioner may adopt regulations to implement the bill's provisions under his existing authority.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2010

### **PREEXISTING CONDITIONS**

The bill requires a health insurer or HMO that, during its investigation of a claim, seeks to discover any preexisting conditions an insured did not disclose on his or her insurance application, to limit its investigation to (1) issues having a direct relationship to the condition specified in the claim and (2) the period before the coverage effective date specified in the preexisting conditions provision of the policy, contract, evidence of coverage, or certificate.

The bill defines a "preexisting conditions provision" as a policy provision that limits or excludes benefits for 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 if breast cancer has reoccurred in a person who was 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; and (3) pregnancy.

By law, the look-back period for purposes of a preexisting condition is the six months (group policy), 12 months (individual policy), or 24 months (short-term policy) immediately preceding the coverage effective date. Under the law, a policy cannot exclude coverage for a preexisting condition for more than 12 months from the insured's

policy effective date.

### **RESCISSION, CANCELLATION, AND LIMITATION DEFINED**

The bill defines a “rescission” as an insurer’s or HMO’s termination of an insurance policy, contract, evidence of coverage, or certificate as of 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.

### **TELEPHONIC APPLICATIONS**

The bill requires an insurer or HMO that accepts applications for individual health insurance coverage over the telephone 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 monthly premium.

The bill also requires the insurer or HMO to mail the applicant a letter that includes a (1) copy of the completed application and (2) notice that the agreement is binding on the applicant unless he or she rescinds it in writing within 10 days after receiving the letter. It specifies that the insurer or HMO may include in the letter a confirmation of the applicant’s agreement to the policy’s or contract’s (1) maximum duration, (2) preexisting condition provisions and exclusionary periods, and (3) monthly premium.

The bill requires the insurer or HMO to keep for two years after the policy’s or contract’s effective date (1) a copy of the letter and any rescission and (2) a recording of the applicant’s complete telephonic application process, in a readily retrievable format.

### **BACKGROUND**

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***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. 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.

***Rescission, Cancellation, or Limitation***

By law, an insurer or HMO must apply for the insurance commissioner's approval, on a form he prescribes, to rescind, cancel, or limit benefits under a health insurance policy, contract, or certificate based on information the insured provided or omitted from his or her insurance application. The insurer or HMO must provide a copy of the completed request form to the enrollee, or enrollee's representative, who then has seven business days to submit relevant information to the commissioner. Within 15 days of receiving the enrollee's submission, the commissioner must mail a written decision to the enrollee; the enrollee's representative, if any; and the insurer or HMO.

Under the law, the commissioner may approve an insurer's or HMO's coverage rescission, cancellation, or limitation if the insured, 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. The law permits an aggrieved person to file an appeal with Hartford Superior Court within 30 days of when the decision is mailed to the affected parties. The court may grant equitable relief.

***Related Laws***

***Insurance Fraud.*** A person is guilty of insurance fraud when he or she, with the intent to injure, defraud, or deceive any insurance company, knowingly gives, or assists in giving, the insurer any false, incomplete, or misleading written or oral statement as part of, or in support of, any insurance application or claim, that is material to the

application or claim. Insurance fraud is a class D felony (CGS § 53a-215).

*General Penalty.* By law, any person or corporation that violates any insurance law that does not have a specified penalty is subject to a fine of up to \$15,000 (CGS § 38a-2).

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 1 (02/16/2010)