



**Substitute House Bill No. 5219**

**Public Act No. 10-13**

**AN ACT EXTENDING STATE CONTINUATION OF HEALTH INSURANCE COVERAGE.**

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

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 Section 38a-538 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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 Section 38a-554 of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553 and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the

**Substitute House Bill No. 5219**

purposes of this section; and (3) unmarried children who are under twenty-six years of age. Each plan shall cover a stepchild on the same basis as a biological child.

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

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

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

(3) [regardless] Regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence

**Substitute House Bill No. 5219**

due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence;

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

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

**Substitute House Bill No. 5219**

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

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

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

**Substitute House Bill No. 5219**

premium if not paid timely by the employee.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans. No individual or group health insurance plan shall coordinate benefits or otherwise reduce benefit payments because a person is covered by or receives benefits from a group specified disease policy delivered, issued for delivery, renewed, amended or continued in this state.

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

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

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

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

(a) Whenever a relocation or closing of a covered establishment

**Substitute House Bill No. 5219**

occurs, the employer of the covered establishment shall pay in full for the continuation of existing group health insurance, no matter where the group policy was written, issued or delivered, for each affected employee and his dependents, if covered under the group policy, from the date of relocation or closing for a period of one hundred twenty days or until such time as the employee becomes eligible for other group coverage, whichever is the lesser, provided any right of such employee and his dependents to a continuation of coverage, [for up to seventy-eight or one hundred fifty-six weeks, as the case may be,] as required by section 38a-538, as amended by this act, or 38a-554, as amended by this act, shall not be affected by the provisions of this section, and provided further the period of continued coverage required by said sections shall not commence until the period of continued coverage established by this section has terminated.

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

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

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

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

**Substitute House Bill No. 5219**

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

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

(3) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of thirty or more hours and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health care plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis. "Eligible employee" shall include any employee who is not actively at work but is covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to [federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, (COBRA)] section 38a-554, as amended by this act, or other applicable laws. [Such employees shall not be counted as eligible employees for the purposes of subsection (4) of this section.]

(4) (A) "Small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than fifty eligible employees, the majority of whom were employed within the state of Connecticut. "Small employer" includes a self-employed individual. [In] For the purposes of determining the number of eligible employees [companies which] under this subdivision: (i) Companies that are affiliated companies, as defined in section 33-840, or [which] that are eligible to file a combined tax return for purposes of taxation under chapter 208 shall be considered one employer; [. Eligible employees shall not include] (ii) employees covered through the employer by

**Substitute House Bill No. 5219**

health insurance plans or insurance arrangements issued to or in accordance with a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act shall not be counted; and (iii) employees who are not actively at work but are covered under the small employer's health insurance plan pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554, as amended by this act, or other applicable laws shall not be counted. Except as otherwise specifically provided, provisions of this section, sections 12-201, 12-211, 12-212a and [38a-564] 38a-565 to 38a-572, inclusive, that apply to a small employer shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

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

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

(6) "Insurance arrangement" means any "multiple employer welfare arrangement", as defined in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, except for any such arrangement [which] that is fully insured within

**Substitute House Bill No. 5219**

the meaning of Section 514(b)(6) of said act, as amended from time to time.

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include (A) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

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

(9) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health insurance plan

**Substitute House Bill No. 5219**

following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, provided an eligible employee or dependent shall not be considered a late enrollee if (A) the request for enrollment is made within thirty days after termination of coverage provided under another group health insurance plan and if the individual had not initially requested coverage under such plan solely because he was covered under another group health insurance plan and coverage under that plan has ceased due to termination of employment, death of a spouse, or divorce, or due to that plan's involuntary termination or cancellation by its carrier for reasons other than nonpayment of premium, or (B) the individual is employed by an employer who offers multiple health insurance plans and the individual elects a different health insurance plan during an open enrollment period, or (C) a court has ordered coverage be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within thirty days after issuance of such court order, or (D) if the request for enrollment is made within thirty days after the marriage of such employee or the birth or adoption of the first child by such employee after the later of the commencement of the employer's plan or the date the pool becomes operational, and satisfactory evidence of such marriage, birth or adoption is provided to the small employer carrier.

(10) "Department" means the Insurance Department.

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

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

**Substitute House Bill No. 5219**

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

(14) "Commissioner" means the Insurance Commissioner.

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

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

(17) "Preexisting conditions provision" means a policy provision which excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a condition which is pregnancy existing on the effective date of coverage.

(18) "Base premium rate" means, as to any health insurance plan or insurance arrangement covering one or more employees of a small employer, the lowest new business premium rate charged by the insurer or insurance arrangement for the same or similar coverage which is equivalent in value under a plan or arrangement covering any

**Substitute House Bill No. 5219**

small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement, except that as to any small employer carrier or insurance arrangement not issuing new health insurance plans or insurance arrangements to a small employer, "base premium rate" means the lowest rate charged a small employer for the same or similar coverage which is equivalent in value, under a plan or arrangement covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement.

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

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

(21) "Health Reinsurance Association" means the entity established and maintained in accordance with the provisions of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, as amended by this act.

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

**Substitute House Bill No. 5219**

by the commissioner.

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

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

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

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

(27) "Case characteristics" means demographic or other objective characteristics of a small employer, including age, sex, family composition, location, size of group, administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259 and industry classification, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of sections 38a-564 to 38a-572, inclusive, as amended by this act.

(28) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance

**Substitute House Bill No. 5219**

with the provisions of subdivisions (4), (6), (7) and (9) of section 38a-567 and the regulations promulgated by the commissioner pursuant to [subdivision (8) of] section 38a-567, as amended by this act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

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

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

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

(B) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely

***Substitute House Bill No. 5219***

corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as stated above only if the carrier effects the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

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

(D) Any individual who was not a late enrollee at the time of his or her enrollment and whose coverage is subsequently rescinded shall be allowed to reenroll as of a current date in such plan or arrangement subject to any preexisting condition or other provisions applicable to new enrollees without previous coverage. On and after the effective date of such individual's reenrollment, the small employer carrier may modify the premium rates charged to the small employer for the balance of the current rating period and for future rating periods, to the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when such individual initially enrolled in the plan. The increase in premium rates allowed by this provision for the balance of the current rating period shall not exceed twenty-five per cent of the small employer's current premium rates. Any such increase for the balance of said current rating period shall not be subject to the rate limitation specified in subdivision (6) of this section.

**Substitute House Bill No. 5219**

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

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

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

(B) For rating periods commencing on or after July 1, 1994, and prior to July 1, 1995, the premium rates charged or offered for a rating period for all plans or arrangements may not exceed one hundred twenty per cent of the base premium rate for such rating period. The provisions of this subdivision shall not apply to any small employer

**Substitute House Bill No. 5219**

who employs more than twenty-five eligible employees.

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

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

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

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

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

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

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall

**Substitute House Bill No. 5219**

not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

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

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

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

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

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the

**Substitute House Bill No. 5219**

small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

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

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

(8) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect

***Substitute House Bill No. 5219***

objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(9) For rating periods commencing prior to July 1, 1995, in any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.

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

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

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

***Substitute House Bill No. 5219***

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

(12) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a special or a small employer health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

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

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

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

(16) If a small employer carrier enters into a contract, agreement or

**Substitute House Bill No. 5219**

other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

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

(18) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have been derived using recognized actuarial principles consistent with the provisions of sections 38a-564 to 38a-573, inclusive, as amended by this act. Such certification shall be in a form and manner and shall contain such information, as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, as amended by this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

**Substitute House Bill No. 5219**

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

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

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

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

(B) With respect to plans or arrangements issued by an association group plan, at the option of the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand

**Substitute House Bill No. 5219**

employees on the date issued, (ii) each small employer is charged or offered the same premium rate with respect to each employee and dependent, and (iii) the plan or plans are written on a guaranteed issue basis. In addition, such association group (I) shall be a bona fide group as set forth in the Employee Retirement and Security Act of 1974, (II) shall not be formed for the purposes of fictitious grouping, as defined in section 38a-827, and (III) shall not issue any plan that shall cause undue disruption in the insurance marketplace, as determined by the commissioner.

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

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

(b) The commissioner may pay under the Medicaid program, within available appropriations, the employee's share of health insurance under an employer's group health insurance plan for employees who would otherwise be eligible for medical assistance.

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

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

**Substitute House Bill No. 5219**

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

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

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

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

(2) Death of a parent;

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

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

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

***Substitute House Bill No. 5219***

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

(7) Self-employment;

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

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

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

Approved May 5, 2010