



General Assembly

February Session, 2014

Raised Bill No. 478

LCO No. 2471



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING THE DUTIES OF THE HEALTH REINSURANCE ASSOCIATION AND REQUIREMENTS OF THE CONNECTICUT SMALL EMPLOYER REINSURANCE POOL, UPDATING THE PREEXISTING CONDITIONS STATUTE, AND CONCERNING SMALL EMPLOYER PREMIUM RATE APPROVAL.

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

1 Section 1. Section 38a-551 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective from passage*):

3 For the purposes of this section and sections 38a-552, as amended by
4 this act, and 38a-556 to 38a-559, inclusive, as amended by this act, the
5 following terms [shall] have the following meanings:

6 [(a)] (1) "Health insurance" or "health care plan" means hospital and
7 medical expenses incurred policies written on a direct basis, nonprofit
8 service plan contracts, health care center contracts and self-insured or
9 self-funded employee health benefit plans. [For purposes of sections
10 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance"]
11 "Health insurance" or "health care plan" does not include [(1)] (A)
12 accident only, credit, dental, vision, Medicare supplement, long-term

13 care or disability insurance, hospital indemnity coverage, coverage
14 issued as a supplement to liability insurance, insurance arising out of a
15 workers' compensation or similar law, automobile medical-payments
16 insurance, or insurance under which beneficiaries are payable without
17 regard to fault and which is statutorily required to be contained in any
18 liability insurance policy or equivalent self-insurance, or [(2)] (B)
19 policies of specified disease or limited benefit health insurance,
20 provided: [(A)] (i) The carrier offering such policies files on or before
21 March first of each year a certification with the commissioner that
22 contains the following: [(i)] (I) A statement from the carrier certifying
23 that such policies are being offered and marketed as supplemental
24 health insurance and not as a substitute for hospital or medical
25 expense insurance; and [(ii)] (II) a summary description of each such
26 policy including the average annual premium rates, or range of
27 premium rates in cases where premiums vary by age, gender or other
28 factors, charged for such policy in the state; and [(B)] (ii) for each such
29 policy that is offered for the first time in this state on or after July 1,
30 2005, the carrier files with the commissioner the information and
31 statement required in subparagraph [(A)] (B)(i) of this subdivision at
32 least thirty days prior to the date such policy is issued or delivered in
33 this state.

34 [(b)] (2) "Carrier" means an insurer, health care center, hospital
35 service corporation or medical service corporation or fraternal benefit
36 society.

37 [(c)] (3) "Insurer" means an insurance company licensed to transact
38 accident and health insurance business in this state.

39 [(d)] (4) "Health care center" [means a health care center, as defined]
40 has the same meaning as provided in section 38a-175.

41 [(e)] (5) "Self-insurer" or "self-insured or self-funded employee
42 health benefit plan" means an employer or an employee welfare
43 benefit fund or plan [which] that provides payment for or

44 reimbursement of the whole or any part of the cost of covered hospital
45 or medical expenses for covered individuals. [For purposes of sections
46 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "self-insurer" shall]
47 "Self-insurer" or "self-insured or self-funded employee health benefit
48 plan" does not include any such employee welfare benefit fund or plan
49 established prior to April 1, 1976, by any organization [which] that is
50 exempt from federal income taxes under the provisions of Section 501
51 of the United States Internal Revenue Code and amendments thereto
52 and legal interpretations thereof, except any such organization
53 described in Subsection (c)(15) of said Section 501.

54 [(f)] (6) "Commissioner" means the Insurance Commissioner. [of the
55 state of Connecticut.]

56 [(g) "Physician" means a doctor of medicine, chiropractic,
57 natureopathy, podiatry, a qualified psychologist and, for purposes of
58 oral surgery only, a doctor of dental surgery or a doctor of medical
59 dentistry and, subject to the provisions of section 20-138d, optometrists
60 duly licensed under the provisions of chapter 380.

61 (h) "Qualified psychologist" means a person who is duly licensed or
62 certified as a clinical psychologist and has a doctoral degree in and at
63 least two years of supervised experience in clinical psychology in a
64 licensed hospital or mental health center.

65 (i) "Skilled nursing facility" shall have the same meaning as "skilled
66 nursing facility", as defined in Section 1395x, Chapter 7 of Title 42,
67 United States Code.

68 (j) "Hospital" shall have the same meaning as "hospital", as defined
69 in Section 1395x, Chapter 7 of Title 42, United States Code.

70 (k) "Home health agency" shall have the same meaning as "home
71 health agency", as defined in Section 1395x, Chapter 7 of Title 42,
72 United States Code.

73 (l) "Copayment" means the portion of a charge that is covered by a
74 plan and not payable by the plan and which is thus the obligation of
75 the covered individual to pay.]

76 [(m)] (Z) "Resident employer" means any person, partnership,
77 association, trust, estate, limited liability company, corporation,
78 whether foreign or domestic, or the legal representative, trustee in
79 bankruptcy or receiver or trustee, thereof, or the legal representative of
80 a deceased person, including the state of Connecticut and each
81 municipality therein [, which] that has in its employ one or more
82 individuals during any calendar year, commencing January 1, 1976.
83 [For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559,
84 inclusive, the term "resident employer" shall refer] "Resident
85 employer" refers only to an employer with a majority of employees
86 employed within the state of Connecticut.

87 [(n) "Eligible employee" means, with respect to any employer, an
88 employee who either is considered a full-time employee, or who is
89 expected to work at least twenty hours a week for at least twenty-six
90 weeks during the next twelve months or who has actually worked at
91 least twenty hours a week for at least twenty-six weeks in any
92 continuous twelve-month period.

93 (o) "Alcoholism treatment facility" shall have the same meaning as
94 in section 38a-533.

95 (p) "Totally disabled" means with respect to an employee, the
96 inability of the employee because of an injury or disease to perform the
97 duties of any occupation for which he is suited by reason of education,
98 training or experience, and, with respect to a dependent, the inability
99 of the dependent because of an injury or disease to engage in
100 substantially all of the normal activities of persons of like age and sex
101 in good health.

102 (q) "Deductible" means the amount of covered expenses which must
103 be accumulated during each calendar year before benefits become

104 payable as additional covered expenses incurred.

105 (r) For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559,
106 inclusive, "disease or injury" shall include pregnancy and resulting
107 childbirth or miscarriage.

108 (s) "Complications of pregnancy" means (1) conditions requiring
109 hospital stays, when the pregnancy is not terminated, whose diagnoses
110 are distinct from pregnancy but are adversely affected by pregnancy or
111 are caused by pregnancy, such as acute nephritis, nephrosis, cardiac
112 decompensation, missed abortion and similar medical and surgical
113 conditions of comparable severity, and shall not include false labor,
114 occasional spotting, physician-prescribed rest during the period of
115 pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia
116 and similar conditions associated with management of a difficult
117 pregnancy not constituting a nosologically distinct complication of
118 pregnancy; and (2) nonelective caesarean section, ectopic pregnancy
119 which is terminated, and spontaneous termination of pregnancy,
120 which occurs during a period of gestation in which a viable birth is not
121 possible.]

122 [(t)] (8) "Resident" means [(1) a person] an individual who maintains
123 a residence in this state for a period of at least one hundred eighty
124 days. [, or (2) a HIPAA or health care tax credit eligible individual who
125 maintains a residence in this state.]

126 [(u) "HIPAA eligible individual" means an eligible individual as
127 defined in subsection (b) of section 2741 of the Public Health Service
128 Act, as set forth in the Health Insurance Portability and Accountability
129 Act of 1996 (P.L. 104-191) (HIPAA).

130 (v) "Health care tax credit eligible individual" means a person who
131 is eligible for the credit for health insurance costs under Section 35 of
132 the Internal Revenue Code of 1986 in accordance with the Pension
133 Benefit Guaranty Corporation and Trade Adjustment Assistance
134 programs of the Trade Act of 2002 (P.L. 107-210).]

135 (9) "Special health care plan" means a health insurance plan issued
136 by the Health Reinsurance Association established under section 38a-
137 556, as amended by this act, for low-income individuals.

138 (10) "Low-income individual" means an individual whose family
139 income is less than three hundred per cent of the federal poverty level
140 for the calendar year prior to the date of application for an individual
141 special health care plan or the year prior to the anniversary of the
142 effective date of such plan, as certified by such individual.

143 (11) "Reimbursement rate" means, with respect to an individual
144 special health care plan, (A) seventy-five per cent of the
145 reimbursement rate payable under Medicare for benefits normally
146 reimbursable under Medicare, or (B) for services and supplies that are
147 not reimbursed by Medicare, seventy-five per cent of the amount that
148 would be payable under Medicare if Medicare was responsible for
149 payment for such services or supplies, as estimated by the board of
150 directors of the Health Reinsurance Association and approved by the
151 Insurance Commissioner.

152 Sec. 2. Section 38a-552 of the general statutes is repealed and the
153 following is substituted in lieu thereof (*Effective from passage*):

154 [(a) (1) Every carrier offering individual health insurance in this
155 state shall, as a condition of transacting such health insurance, make an
156 individual comprehensive health care plan, described in section 38a-
157 555, available to every resident of this state except residents who are
158 both sixty-five years of age or older and eligible for Medicare.
159 Individual comprehensive health care plans may be made available
160 through participation in the Health Reinsurance Association in
161 accordance with section 38a-556, or a residual market association, in
162 accordance with section 38a-557. The premium charged for such a plan
163 which is not insured by or through the Health Reinsurance Association
164 or any other residual market association may not exceed the premium
165 which would be applicable through participation in such associations.

166 The premium charged for such a plan insured by or through the
167 Health Reinsurance Association shall be precisely the premium
168 established for that particular classification under the Health
169 Reinsurance Association. (2) Every self-insurer whose plan covers
170 three or more employees shall make an individual comprehensive
171 health care plan, described in section 38a-555, available under a
172 conversion privilege to every person covered by the plan who is a
173 resident of this state, who is not eligible for Medicare and whose
174 coverage under the self-insured plan ceases as a result of layoff, death
175 or termination of employment. The individual comprehensive health
176 care plans may be provided through a carrier or through participation
177 in the Health Reinsurance Association in accordance with section 38a-
178 556. The premium charged for such a plan which is not insured by or
179 through the Health Reinsurance Association may not exceed the
180 premium established for that particular classification under the Health
181 Reinsurance Association. The premium charged for such a plan which
182 is insured by or through the Health Reinsurance Association shall be
183 precisely the premium established for that particular classification
184 under the Health Reinsurance Association.

185 (b) Every carrier offering group health insurance in this state shall,
186 as a condition of transacting such health insurance, make a group
187 comprehensive health care plan, as described in section 38a-554,
188 available to every resident employer who is not a small employer as
189 defined in subdivision (4) of section 38a-564.

190 (c) Except as provided in subdivision (c) of section 38a-505, nothing
191 in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, shall
192 preclude the right of carriers to transact other kinds of insurance for
193 which they are authorized, nor preclude the right of carriers to transact
194 any other lawful kind of health insurance.

195 (d) Nothing in sections 38a-505, 38a-546 and 38a-551 to 38a-559,
196 inclusive, shall require a carrier to make available coverage under a
197 group or individual comprehensive health care plan to any person or

198 group who is already covered under such a plan.]

199 No individual or organization that provides medical advice,
200 diagnosis, care or treatment of a type covered under a special health
201 care plan shall provide such service to any person in this state unless
202 such individual or organization provides such service, upon request,
203 on the basis of the applicable reimbursement rate, to low-income
204 individuals or their dependents covered under such special health care
205 plans.

206 Sec. 3. Section 38a-556 of the general statutes is repealed and the
207 following is substituted in lieu thereof (*Effective from passage*):

208 (a) There is hereby created a nonprofit legal entity to be known as
209 the Health Reinsurance Association. All insurers, health care centers
210 and self-insurers doing business in the state, as a condition to their
211 authority to transact the applicable kinds of health insurance defined
212 in section 38a-551, as amended by this act, shall be members of the
213 association. The association shall perform its functions under a plan of
214 operation established and approved under subsection [(a)] (b) of this
215 section, and shall exercise its powers through a board of directors
216 established under this section.

217 [(a)] (b) (1) The board of directors of the association shall be made
218 up of nine individuals selected by participating members, subject to
219 approval by the commissioner, two of whom shall be appointed by the
220 commissioner on or before July 1, 1993, to represent health care
221 centers. To select the initial board of directors, and to initially organize
222 the association, the commissioner shall give notice to all members of
223 the time and place of the organizational meeting. In determining
224 voting rights at the organizational meeting each member shall be
225 entitled to vote in person or proxy. The vote shall be a weighted vote
226 based upon the net health insurance premium derived from this state
227 in the previous calendar year. If the board of directors is not selected
228 within sixty days after notice of the organizational meeting, the

229 commissioner may appoint the initial board. In approving or selecting
230 members of the board, the commissioner may consider, among other
231 things, whether all members are fairly represented. Members of the
232 board may be reimbursed from the moneys of the association for
233 expenses incurred by them as members, but shall not otherwise be
234 compensated by the association for their services.

235 (2) The board shall submit to the commissioner a plan of operation
236 for the association necessary or suitable to assure the fair, reasonable
237 and equitable administration of the association. The plan of operation
238 shall become effective upon approval in writing by the commissioner,
239 [consistent with the date on which the coverage under sections 38a-
240 505, 38a-546 and 38a-551 to 38a-559, inclusive, must be made available.
241 The commissioner shall, after notice and hearing, approve the plan of
242 operation provided such plan is determined to be suitable to assure the
243 fair, reasonable and equitable administration of the association, and
244 provides for the sharing of association gains or losses on an equitable
245 proportionate basis. If the board fails to submit a suitable plan of
246 operation within one hundred eighty days after its appointment, or if
247 at any time thereafter the board fails to submit suitable amendments to
248 the plan, the commissioner shall, after notice and hearing, adopt and
249 promulgate such reasonable rules as are necessary or advisable to
250 effectuate the provisions of this section. Such rules] Such plan shall
251 continue in force until modified by the commissioner or superseded by
252 a plan submitted by the board and approved by the commissioner. The
253 plan of operation shall: [, in addition to requirements enumerated in
254 sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive:] (A)
255 Establish procedures for the handling and accounting of assets and
256 moneys of the association; (B) establish regular times and places for
257 meetings of the board of directors; (C) establish procedures for records
258 to be kept of all financial transactions, and for the annual fiscal
259 reporting to the commissioner; (D) establish procedures whereby
260 selections for the board of directors shall be made and submitted to the
261 commissioner; (E) establish procedures to amend, subject to the

262 approval of the commissioner, the plan of operations; (F) establish
263 procedures for the selection of an administrator and set forth the
264 powers and duties of the administrator; (G) contain additional
265 provisions necessary or proper for the execution of the powers and
266 duties of the association; and (H) [establish procedures for the
267 advertisement on behalf of all participating carriers of the general
268 availability of the comprehensive coverage under sections 38a-505,
269 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional
270 provisions necessary for the association to qualify as an acceptable
271 alternative mechanism in accordance with Section 2744 of the Public
272 Health Service Act, as set forth in the Health Insurance Portability and
273 Accountability Act of 1996, P.L. 104-191; and (J)] contain additional
274 provisions necessary for the association to establish health insurance
275 plans that qualify as acceptable coverage in accordance with the
276 Pension Benefit Guaranty Corporation and [Trade Adjustment
277 Assistance programs of the Trade Act of 2002, P.L. 107-210. The
278 commissioner may adopt regulations, in accordance with the
279 provisions of chapter 54, to establish criteria for the association to
280 qualify as an acceptable alternative mechanism] other state or federal
281 programs that may be established.

282 [(b)] (c) The association shall have the general powers and authority
283 granted under the laws of this state to carriers to transact the kinds of
284 insurance defined under section 38a-551, and in addition thereto, the
285 specific authority to: (1) Enter into contracts necessary or proper to
286 carry out the provisions and purposes of sections [38a-505, 38a-546
287 and] 38a-551, as amended by this act, and 38a-556 to 38a-559, inclusive,
288 as amended by this act; (2) sue or be sued, including taking any legal
289 actions necessary or proper for recovery of any assessments for, on
290 behalf of, or against participating members; (3) take such legal action
291 as necessary to avoid the payment of improper claims against the
292 association or the coverage provided by or through the association; (4)
293 establish, with respect to health insurance provided by or on behalf of
294 the association, appropriate rates, scales of rates, rate classifications

295 and rating adjustments, such rates not to be unreasonable in relation to
296 the coverage provided and the operational expenses of the association;
297 (5) administer any type of reinsurance program, for or on behalf of
298 participating members; (6) pool risks among participating members;
299 (7) issue policies of insurance [on an indemnity or provision of service
300 basis providing the coverage] required or permitted by sections [38a-
301 505, 38a-546 and] 38a-551, as amended by this act, and 38a-556 to 38a-
302 559, inclusive, as amended by this act, in its own name or on behalf of
303 participating members; (8) administer separate pools, separate
304 accounts or other plans as deemed appropriate for separate members
305 or groups of members; (9) operate and administer any combination of
306 plans, pools, reinsurance arrangements or other mechanisms as
307 deemed appropriate to best accomplish the fair and equitable
308 operation of the association; (10) set limits on the amounts of
309 reinsurance that may be ceded to the association by its members; (11)
310 appoint from among participating members appropriate legal,
311 actuarial and other committees as necessary to provide technical
312 assistance in the operation of the association, policy and other contract
313 design, and any other function within the authority of the association;
314 [and] (12) apply for and accept grants, gifts and bequests of funds from
315 other states, federal and interstate agencies and independent
316 authorities, private firms, individuals and foundations for the purpose
317 of carrying out its responsibilities. Any such funds received shall be
318 deposited in the General Fund and shall be credited to a separate
319 nonlapsing account within the General Fund for the Health
320 Reinsurance Association and may be used by the Health Reinsurance
321 Association in the performance of its duties; and (13) perform such
322 other duties and responsibilities as may be required by state or federal
323 law or permitted by state or federal law and approved by the
324 Insurance Commissioner.

325 [(c) Every member shall participate in the association in accordance
326 with the provisions of this subsection. (1) A participating member shall
327 determine the particular risks it elects to have written by or through

328 the association. A member shall designate which of the following
329 classes of risks it shall underwrite in the state, from which classes of
330 risk it may elect to reinsure selected risks: (A) Individual, excluding
331 group conversion; and (B) individual, including group conversion. (2)
332 No member shall be permitted to select out individual lives from an
333 employer group to be insured by or through the association. Members
334 electing to administer risks that are insured by or through the
335 association shall comply with the benefit determination guidelines and
336 the accounting procedures established by the association. A risk
337 insured by or through the association cannot be withdrawn by the
338 participating member except in accordance with the rules established
339 by the association. (3)]

340 (d) Rates for coverage issued by or through the association shall not
341 be excessive, inadequate or unfairly discriminatory. [Separate scales of
342 premium rates based on age shall apply, but rates shall not be adjusted
343 for area variations in provider costs. Premium rates shall take into
344 consideration the substantial extra morbidity and administrative
345 expenses for association risks, reimbursement or reasonable expenses
346 incurred for the writing of association risks and the level of rates
347 charged by insurers for groups of ten lives, provided incurred losses
348 that result from provision of coverage in accordance with section 38a-
349 537 shall not be considered. In no event shall the rate for a given
350 classification or group be less than one hundred twenty-five per cent
351 or more than one hundred fifty per cent of the average rate charged for
352 that classification with similar characteristics under a policy covering
353 ten lives.] All rates shall be promulgated by the association through an
354 actuarial committee consisting of five persons who are members of the
355 American Academy of Actuaries, shall be filed with the commissioner
356 and may be disapproved within sixty days from the filing thereof if
357 excessive, inadequate or unfairly discriminatory.

358 [(d)] (e) (1) Following the close of each fiscal year, the administrator
359 shall determine the net premiums, reinsurance premiums less
360 administrative expense allowance, the expense of administration

361 pertaining to the reinsurance operations of the association and the
362 incurred losses for the year. Any net loss shall be assessed to all
363 participating members in proportion to their respective shares of the
364 total health insurance premiums earned in this state during the
365 calendar year, or with paid losses in the year, coinciding with or
366 ending during the fiscal year of the association or on any other
367 equitable basis as may be provided in the plan of operations. For self-
368 insured members of the association, health insurance premiums
369 earned shall be established by dividing the amount of paid health
370 losses for the applicable period by eighty-five per cent. Net gains, if
371 any, shall be held at interest to offset future losses or allocated to
372 reduce future premiums.

373 (2) Any net loss to the association represented by the excess of its
374 actual expenses of administering policies issued by the association
375 over the applicable expense allowance shall be separately assessed to
376 those participating members who do not elect to administer their
377 plans. All assessments shall be on an equitable formula established by
378 the board.

379 (3) The association shall conduct periodic audits to assure the
380 general accuracy of the financial data submitted to the association and
381 the association shall have an annual audit of its operations by an
382 independent certified public accountant. The annual audit shall be
383 filed with the commissioner for his review and the association shall be
384 subject to the provisions of section 38a-14.

385 [(4) For the fiscal year ending December 31, 1993, and the first
386 quarter of the fiscal year ending December 31, 1994, the administrator
387 shall not include health care centers in assessing any net losses to
388 participating members.]

389 [(e)] (f) All policy forms issued by or through the association shall
390 conform in substance to prototype forms developed by the association,
391 shall in all other respects conform to the requirements of sections [38a-

392 505, 38a-546 and] 38a-551, as amended by this act, and 38a-556 to 38a-
393 559, inclusive, as amended by this act, and shall be approved by the
394 commissioner. The commissioner may disapprove any such form if it
395 contains a provision or provisions [which] that are unfair or deceptive
396 or [which] that encourage misrepresentation of the policy.

397 [(f)] (g) Unless otherwise permitted by the plan of operation, the
398 association shall not issue, reissue or continue in force
399 [comprehensive] health care plan coverage with respect to any person
400 who is already covered under an individual or group [comprehensive]
401 health care plan, or who is sixty-five years of age or older and eligible
402 for Medicare or who is not a resident of this state. [Coverage provided
403 to a HIPAA or health care tax credit eligible individual may be
404 terminated to the extent permitted by HIPAA or the Trade Act of 2002,
405 respectively.]

406 [(g)] (h) Benefits payable under a [comprehensive] health care plan
407 insured by or reinsured through the association shall be paid net of all
408 other health insurance benefits paid or payable through any other
409 source, and net of all health insurance coverages provided by or
410 pursuant to any other state or federal law including Title XVIII of the
411 Social Security Act, Medicare, but excluding Medicaid.

412 [(h)] (i) There shall be no liability on the part of and no cause of
413 action of any nature shall arise against any carrier or its agents or its
414 employees, the Health Reinsurance Association or its agents or its
415 employees or the residual market mechanism established under the
416 provisions of section 38a-557, as amended by this act, or its agents or
417 its employees, or the commissioner or [his] the commissioner's
418 representatives for any action taken by them in the performance of
419 their duties under sections [38a-505, 38a-546 and] 38a-551, as amended
420 by this act, and 38a-556 to 38a-559, inclusive, as amended by this act.
421 This provision shall not apply to the obligations of a carrier, a self-
422 insurer, the Health Reinsurance Association or the residual market
423 mechanism for payment of benefits provided under a [comprehensive]

424 health care plan.

425 Sec. 4. Section 38a-557 of the general statutes is repealed and the
426 following is substituted in lieu thereof (*Effective from passage*):

427 (a) Hospital service corporations and medical service corporations
428 may [elect to meet the obligations of section 38a-552 by participating]
429 participate in the Health Reinsurance Association established in
430 section 38a-556, as amended by this act, as a full member thereof, or by
431 making [comprehensive] health care plans available directly through a
432 subscriber contract or combination of contracts or by forming a
433 separate residual market mechanism substantially similar to [the
434 association established in section 38a-556] said association.

435 (b) In the event that hospital service corporations and medical
436 service corporations choose to form a separate residual market
437 mechanism, the commissioner shall have the same regulatory powers
438 over that residual market mechanism as the commissioner has over the
439 Health Reinsurance Association, and such residual market mechanism
440 shall have the same powers and duties as the association. Rating
441 classifications under a residual market mechanism established under
442 this section need not be the same as classifications established under
443 the association, but any rates established by the residual market
444 mechanism shall be approved by the commissioner. The commissioner
445 shall [promulgate] adopt regulations in accordance with the provisions
446 of chapter 54 to carry out the requirements of this section.

447 (c) If hospital service corporations and medical service corporations
448 do not elect to participate in the Health Reinsurance Association, such
449 service corporations shall be required to make an individual
450 [comprehensive] health care plan available to every resident of this
451 state except residents who are both sixty-five years of age or older and
452 eligible for Medicare and whose coverage under a group or individual
453 contract issued by such service corporations has terminated. Such
454 coverage may be made available through a separate residual market

455 mechanism established under this section.

456 Sec. 5. Section 38a-564 of the general statutes is repealed and the
457 following is substituted in lieu thereof (*Effective from passage*):

458 As used in this section and sections [12-201, 12-211, 12-212a and 38a-
459 565 to 38a-572, inclusive] 38a-566, as amended by this act, 38a-567, as
460 amended by this act, 38a-569, as amended by this act, and 38a-574, as
461 amended by this act:

462 (1) "Pool" means the Connecticut Small Employer Health
463 Reinsurance Pool, established under section 38a-569, as amended by
464 this act.

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

466 [(3) "Eligible employee" means an employee who works a normal
467 work week of twenty or more hours and includes a sole proprietor, a
468 partner of a partnership or an independent contractor, provided such
469 sole proprietor, partner or contractor is included as an employee under
470 a health care plan of a small employer but does not include an
471 employee who works on a seasonal, temporary or substitute basis.
472 "Eligible employee" shall include any employee who is not actively at
473 work but is covered under the small employer's health insurance plan
474 pursuant to (A) workers' compensation, (B) continuation of benefits
475 pursuant to section 38a-554, or (C) other applicable laws.

476 (4) (A) "Small employer" means any person, firm, corporation,
477 limited liability company, partnership or association actively engaged
478 in business or self-employed for at least three consecutive months
479 who, on at least fifty per cent of its working days during the preceding
480 twelve months, employed no more than fifty eligible employees, the
481 majority of whom were employed within the state of Connecticut.
482 "Small employer" includes a self-employed individual. For the
483 purposes of determining the number of eligible employees under this
484 subdivision: (i) Companies that are affiliated companies, as defined in

485 section 33-840, or that are eligible to file a combined tax return for
486 purposes of taxation under chapter 208 shall be considered one
487 employer; (ii) employees covered through the employer by health
488 insurance plans or insurance arrangements issued to or in accordance
489 with a trust established pursuant to collective bargaining subject to the
490 federal Labor Management Relations Act shall not be counted; (iii)
491 employees who are not actively at work but are covered under the
492 small employer's health insurance plan pursuant to workers'
493 compensation, continuation of benefits pursuant to section 38a-554 or
494 other applicable laws shall not be counted; and (iv) employees who
495 work a normal work week of less than thirty hours shall not be
496 counted. Except as otherwise specifically provided, provisions of this
497 section and sections 12-201, 12-211, 12-212a and 38a-565 to 38a-572,
498 inclusive, that apply to a small employer shall continue to apply until
499 the plan anniversary following the date the employer no longer meets
500 the requirements of this definition.

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

513 (3) "Employee" means an individual employed by an employer.
514 "Employee" does not include (A) an individual and such individual's
515 spouse with respect to an incorporated or unincorporated trade or
516 business that is wholly owned by such individual, by such individual's
517 spouse or by such individual and such individual's spouse, or (B) a

518 partner in a partnership and such partner's spouse with respect to such
519 partnership.

520 (4) (A) "Small employer" means an employer that, (i) prior to
521 January 1, 2016, employed an average of at least one but not more than
522 fifty employees on business days during the preceding calendar year
523 and employs at least one employee on the first day of the group health
524 insurance plan year, and (ii) on and after January 1, 2016, employed an
525 average of at least one but not more than one hundred employees on
526 business days during the preceding calendar year and employs at least
527 one employee on the first day of the group health insurance plan year.
528 "Small employer" does not include a sole proprietorship that employs
529 only the sole proprietor or the spouse of such sole proprietor.

530 (B) (i) For purposes of subparagraph (A) of this subdivision, the
531 number of employees shall be determined by adding (I) the number of
532 full-time employees for each month who work a normal work week of
533 thirty hours or more and (II) the number of full-time equivalent
534 employees, calculated for each month by dividing by one hundred
535 twenty the aggregate number of hours worked for such month by
536 employees who work a normal work week of less than thirty hours,
537 and averaging such total for the calendar year.

538 (ii) If an employer was not in existence throughout the preceding
539 calendar year, the number of employees shall be based on the average
540 number of employees that such employer reasonably expects to
541 employ in the current calendar year.

542 (C) All persons treated as a single employer under Section 414 of the
543 Internal Revenue Code of 1986, or any subsequent corresponding
544 internal revenue code of the United States, as amended from time to
545 time, shall be considered a single employer for purposes of this
546 subdivision.

547 (5) "Insurer" means any insurance company, hospital [or] service
548 corporation, medical service corporation [,] or health care center,

549 authorized to transact health insurance business in this state.

550 (6) "Insurance arrangement" means any multiple employer welfare
551 arrangement, as defined in Section 3 of the Employee Retirement
552 Income Security Act of 1974, [(ERISA),] as amended from time to time,
553 except for any such arrangement that is fully insured within the
554 meaning of Section 514(b)(6) of said act, as amended from time to time.

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

580 (8) "Plan of operation" means the plan of operation of the pool,

581 including articles, bylaws and operating rules, adopted by the board
582 pursuant to section 38a-569, as amended by this act.

583 [(9) "Late enrollee" means an eligible employee or dependent who
584 requests enrollment in a small employer's health insurance plan
585 following the initial enrollment period provided under the terms of the
586 first plan for which such employee or dependent was eligible through
587 such small employer, provided an eligible employee or dependent
588 shall not be considered a late enrollee if (A) the request for enrollment
589 is made within thirty days after termination of coverage provided
590 under another group health insurance plan and if the individual had
591 not initially requested coverage under such plan solely because he was
592 covered under another group health insurance plan and coverage
593 under that plan has ceased due to termination of employment, death of
594 a spouse, or divorce, or due to that plan's involuntary termination or
595 cancellation by its carrier for reasons other than nonpayment of
596 premium, or (B) the individual is employed by an employer who offers
597 multiple health insurance plans and the individual elects a different
598 health insurance plan during an open enrollment period, or (C) a court
599 has ordered coverage be provided for a spouse or minor child under a
600 covered employee's plan and request for enrollment is made within
601 thirty days after issuance of such court order, or (D) if the request for
602 enrollment is made within thirty days after the marriage of such
603 employee or the birth or adoption of the first child by such employee
604 after the later of the commencement of the employer's plan or the date
605 the pool becomes operational, and satisfactory evidence of such
606 marriage, birth or adoption is provided to the small employer carrier.

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

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

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

615 [(13)] (9) "Dependent" means the spouse or child of an [eligible]
616 employee, subject to applicable terms of the health insurance plan
617 covering such employee. "Dependent" [shall also include] includes any
618 dependent that is covered under the small employer's health insurance
619 plan pursuant to workers' compensation, continuation of benefits
620 pursuant to section [38a-554] 38a-512a, as amended by this act, or other
621 applicable laws.

622 [(14)] (10) "Commissioner" means the Insurance Commissioner.

623 [(15)] (11) "Member" means each insurer and insurance arrangement
624 participating in the pool.

625 [(16)] (12) "Small employer carrier" means any insurer or insurance
626 arrangement [which] that offers or maintains group health insurance
627 plans covering [eligible] employees of one or more small employers.

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

636 (18) "Base premium rate" means, as to any health insurance plan or
637 insurance arrangement covering one or more employees of a small
638 employer, the lowest new business premium rate charged by the
639 insurer or insurance arrangement for the same or similar coverage
640 which is equivalent in value under a plan or arrangement covering any
641 small employer with similar case characteristics, other than claim

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

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

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

660 (21) "Health Reinsurance Association" means the entity established
661 and maintained in accordance with the provisions of sections 38a-505,
662 38a-546 and 38a-551 to 38a-559, inclusive.

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

672 (23) "Individual special health care plan" means a health insurance

673 plan for individuals, issued by the Health Reinsurance Association in
674 accordance with section 38a-571 or issued by an insurer in accordance
675 with section 38a-565.

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

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

685 [(26)] (13) "Health care center" [means health care center as defined]
686 has the same meaning as provided in section 38a-175.

687 [(27)] (14) "Case characteristics" means demographic or other
688 objective characteristics of a small employer, including age [, sex,
689 family composition, location, size of group, administrative cost savings
690 resulting from the administration of an association group plan or a
691 plan written pursuant to section 5-259 and industry classification, as
692 determined by a small employer carrier, that are considered by the
693 small employer carrier in the determination of premium rates for the
694 small employer. Claim] and geographic location. "Case characteristics"
695 does not include claims experience, health status [, and] or duration of
696 coverage since issue. [are not case characteristics for the purpose of
697 sections 38a-564 to 38a-572, inclusive.]

698 [(28) "Actuarial certification" means a written statement by a
699 member of the American Academy of Actuaries or other individual
700 acceptable to the commissioner that a small employer carrier is in
701 compliance with the provisions of subdivisions (4), (6), (7) and (9) of
702 section 38a-567 and the regulations promulgated by the commissioner
703 pursuant to section 38a-567, based upon the person's examination,

704 including a review of the appropriate records and of the actuarial
705 assumptions and methods used by the small employer carrier in
706 establishing premium rates for applicable health benefit plans.]

707 Sec. 6. Section 38a-566 of the general statutes is repealed and the
708 following is substituted in lieu thereof (*Effective from passage*):

709 (a) Any individual or group health insurance plan or any insurance
710 arrangement shall be subject to the provisions of sections [12-201, 12-
711 211, 12-212a and] 38a-552, as amended by this act, 38a-564, as amended
712 by this act, [to 38a-572, inclusive] 38a-567, as amended by this act, and
713 38a-569, as amended by this act, if it provides health insurance or is an
714 insurance arrangement covering one or more employees of a small
715 employer and if any one of the following conditions are met:

716 (1) Any portion of the premium or benefits is paid by a small
717 employer or any covered individual is reimbursed, whether through
718 wage adjustments or otherwise, by a small employer for any portion of
719 the premium; or

720 (2) The health insurance plan or arrangement is treated by the
721 employer or any of the covered individuals as part of a plan or
722 program for the purposes of Section 162 or Section 106 of the United
723 States Internal Revenue Code.

724 (b) Nothing in this section shall be construed to apply the provisions
725 of sections 12-202 and 12-212a, as amended by this act, to health care
726 centers.

727 (c) Notwithstanding the provisions of subsection (a) of this section,
728 health insurance plans or insurance arrangements issued to or in
729 accordance with a trust established pursuant to collective bargaining,
730 subject to the federal Labor Management Relations Act and which
731 cover, in the aggregate, more than twenty-five employees of all
732 participating employers, shall not be subject to the provisions of
733 section 38a-567, as amended by this act, or subparagraph (A) of

734 subdivision (2) of subsection [(e)] (c) of section 38a-569, as amended by
735 this act. [and insurers or insurance arrangements issuing only such
736 plans shall not be considered small employer carriers for purposes of
737 sections 38a-565 and 38a-568.]

738 (d) A small employer carrier that ceases marketing to small
739 employers [as provided in subsection (d) of section 38a-568] shall not
740 cease enrolling new employers in a policy issued to provide coverage
741 to the members of a trade association or to a trust on behalf of a trade
742 association if the following conditions exist:

743 (1) Such trade association is a not-for-profit trade association
744 qualified under 26 USC Section 501c(6), was not formed solely for the
745 purpose of providing insurance and has been operating continuously
746 for at least twenty-five years; [.]

747 (2) The policy issued to or on behalf of such association was in
748 existence prior to June 1, 1990, and has annual premiums of less than
749 twenty-five million dollars; [.]

750 (3) Such policy is offered on a guaranteed issue basis to all small
751 employer members and only to members of such trade association.

752 [(e) Subsection (a) of this section shall not apply to an individual
753 health insurance plan issued to a self-employed individual if the
754 carrier discloses on the application and marketing materials, in not less
755 than ten-point type, the following notice: "THIS PLAN IS ISSUED ON
756 AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL
757 HEALTH INSURANCE PLAN."]

758 Sec. 7. Section 38a-567 of the general statutes is repealed and the
759 following is substituted in lieu thereof (*Effective from passage*):

760 Health insurance plans, associations of small employers and other
761 insurance arrangements covering small employers and insurers and
762 producers marketing such plans and arrangements shall be subject to

763 the following provisions:

764 [(1) (A) (i) Any such insurer or producer marketing such plans or
765 arrangements shall offer premium quotes to small employers upon
766 request for coverage for employees who work a normal work week of
767 thirty or more hours. Upon request by a small employer, such insurer
768 or producer shall offer premium quotes for coverage for employees
769 that include those who work a normal work week of at least twenty
770 hours.

771 (ii) No small employer that has requested premium quotes for
772 coverage for employees that include those who work a normal work
773 week of less than thirty hours shall be required to accept such quotes
774 or coverage in lieu of premium quotes or coverage for only those
775 employees who work a normal work week of thirty or more hours.

776 (iii) Nothing in this subparagraph shall require a small employer
777 that offers coverage to its employees who work a normal work week of
778 thirty hours or more to offer coverage to its employees who work a
779 normal work week of less than thirty hours.]

780 (1) (A) Any such plan or arrangement shall be offered on a
781 guaranteed issue basis with respect to all eligible employees or
782 dependents of such employees, at the option of the small employer,
783 policyholder or contractholder, as the case may be.

784 (B) Any such plan or arrangement shall be renewable with respect
785 to all eligible employees or dependents at the option of the small
786 employer, policyholder or contractholder, as the case may be, except:
787 (i) For nonpayment of the required premiums by the small employer,
788 policyholder or contractholder; (ii) for fraud or misrepresentation of
789 the small employer, policyholder or contractholder or, with respect to
790 coverage of individual insured, the insureds or their representatives;
791 (iii) for noncompliance with plan or arrangement provisions; (iv) when
792 the number of insureds covered under the plan or arrangement is less
793 than the number of insureds or percentage of insureds required by

794 participation requirements under the plan or arrangement; or (v) when
795 the small employer, policyholder or contractholder is no longer
796 actively engaged in the business in which it was engaged on the
797 effective date of the plan or arrangement.

798 (C) Renewability of coverage may be effected by either continuing
799 in effect a plan or arrangement covering a small employer or by
800 substituting upon renewal for the prior plan or arrangement the plan
801 or arrangement then offered by the carrier that most closely
802 corresponds to the prior plan or arrangement and is available to other
803 small employers. Such substitution shall only be made under
804 conditions approved by the commissioner. A carrier may substitute a
805 plan or arrangement as [stated above] set forth in this subparagraph
806 only if the carrier effects the same substitution upon renewal for all
807 small employers previously covered under the particular plan or
808 arrangement, unless otherwise approved by the commissioner. The
809 substitute plan or arrangement shall be subject to the rating restrictions
810 specified in this section on the same basis as if no substitution had
811 occurred, except for an adjustment based on coverage differences.

812 [(D) Notwithstanding the provisions of this subdivision, any such
813 plan or arrangement, or any coverage provided under such plan or
814 arrangement may be rescinded for fraud, intentional material
815 misrepresentation or concealment by an applicant, employee,
816 dependent or small employer.

817 (E) Any individual who was not a late enrollee at the time of his or
818 her enrollment and whose coverage is subsequently rescinded shall be
819 allowed to reenroll as of a current date in such plan or arrangement
820 subject to any preexisting condition or other provisions applicable to
821 new enrollees without previous coverage. On and after the effective
822 date of such individual's reenrollment, the small employer carrier may
823 modify the premium rates charged to the small employer for the
824 balance of the current rating period and for future rating periods, to
825 the level determined by the carrier as applicable under the carrier's

826 established rating practices had full, accurate and timely underwriting
827 information been supplied when such individual initially enrolled in
828 the plan. The increase in premium rates allowed by this provision for
829 the balance of the current rating period shall not exceed twenty-five
830 per cent of the small employer's current premium rates. Any such
831 increase for the balance of said current rating period shall not be
832 subject to the rate limitation specified in subdivision (6) of this section.
833 The rate limitation specified in this section shall otherwise be fully
834 applicable for the current and future rating periods. The modification
835 of premium rates allowed by this subdivision shall cease to be
836 permitted for all plans and arrangements on the first rating period
837 commencing on or after July 1, 1995.

838 (2) Except in the case of a late enrollee who has failed to provide
839 evidence of insurability satisfactory to the insurer, the plan or
840 arrangement may not exclude any eligible employee or dependent
841 who would otherwise be covered under such plan or arrangement on
842 the basis of an actual or expected health condition of such person. No
843 plan or arrangement may exclude an eligible employee or eligible
844 dependent who, on the day prior to the initial effective date of the plan
845 or arrangement, was covered under the small employer's prior health
846 insurance plan or arrangement pursuant to workers' compensation,
847 continuation of benefits pursuant to section 38a-554 or other applicable
848 laws. The employee or dependent must request coverage under the
849 new plan or arrangement on a timely basis and such coverage shall
850 terminate in accordance with the provisions of the applicable law.

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

856 (B) For rating periods commencing on or after July 1, 1994, and prior
857 to July 1, 1995, the premium rates charged or offered for a rating

858 period for all plans or arrangements may not exceed one hundred
859 twenty per cent of the base premium rate for such rating period. The
860 provisions of this subdivision shall not apply to any small employer
861 who employs more than twenty-five eligible employees.

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

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

869 (B) An adjustment of the small employer's premium rates for the
870 prior rating period, and adjusted pro rata for rating periods of less
871 than one year, due to the claim experience, health status or duration of
872 coverage of the employees or dependents of the small employer, such
873 adjustment (i) not to exceed ten per cent annually for the rating
874 periods commencing on or after October 1, 1993, and prior to July 1,
875 1994, and (ii) not to exceed five per cent annually for the rating periods
876 commencing on or after July 1, 1994, and prior to July 1, 1995; and

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

880 (D) Any such plan or arrangement shall provide special enrollment
881 periods (i) to all eligible employees or dependents as set forth in 45
882 CFR 147.104, as amended from time to time, and (ii) for coverage
883 under such plan or arrangement ordered by a court for a spouse or
884 minor child of an eligible employee where request for enrollment is
885 made not later than thirty days after the issuance of such court order.

886 [(5) (A)] (2) (A) With respect to grandfathered plans [or
887 arrangements issued on or after July 1, 1995] issued to small

888 employers, the premium rates charged or offered [to small employers]
889 shall be established on the basis of a [community rate] single pool of all
890 grandfathered plans, adjusted to reflect one or more of the following
891 classifications:

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

894 (ii) Gender;

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

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

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

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

914 (vii) Savings resulting from a reduction in the profit of a carrier
915 [who] that writes small business plans or arrangements for an
916 association group plan or a plan written pursuant to section 5-259, as

917 amended by this act, provided any loss in overall revenue due to a
918 reduction in profit is not shifted to other small employers; and

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

924 [(B) The small employer carrier shall quote premium rates to small
925 employers after receipt of all demographic rating classifications of the
926 small employer group. No small employer carrier may inquire
927 regarding health status or claims experience of the small employer or
928 its employees or dependents prior to the quoting of a premium rate.

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

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

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

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

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

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

975 (B) (i) With respect to nongrandfathered plans issued to small
976 employers, the premium rates charged or offered shall be established
977 on the basis of a single pool of all nongrandfathered plans, adjusted to
978 reflect one or more of the following classifications:

979 (I) Age, in accordance with a uniform age rating curve established
980 by the commissioner;

981 (II) Geographic area, as defined by the commissioner.

982 (ii) Total premium rates for family coverage for nongrandfathered
983 plans shall be determined by adding the premiums for each individual
984 family member, except that with respect to family members under
985 twenty-one years of age, the premiums for only the three oldest
986 covered children shall be taken into account in determining the total
987 premium rate for such family.

988 (iii) Premium rates for employees and dependents for
989 nongrandfathered plans shall be calculated for each covered individual
990 and premium rates for the small employer group shall be calculated by
991 totaling the premiums attributable to each covered individual.

992 (C) Premium rates for any given plan may vary by actuarially
993 justified differences in plan design.

994 (D) For purposes of this subdivision, "grandfathered plan" has the
995 same meaning as "grandfathered health plan" as provided in the
996 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
997 from time to time.

998 [(11)] (3) No small employer carrier or producer shall, directly or
999 indirectly, engage in the following activities:

1000 (A) Encouraging or directing small employers to refrain from filing
1001 an application for coverage with the small employer carrier because of
1002 the health status, claims experience, industry, occupation or
1003 geographic location of the small employer, except the provisions of
1004 this subparagraph shall not apply to information provided by a small
1005 employer carrier or producer to a small employer regarding the
1006 carrier's established geographic service area or a restricted network
1007 provision of a small employer carrier; or

1008 (B) Encouraging or directing small employers to seek coverage from
1009 another carrier because of the health status, claims experience,
1010 industry, occupation or geographic location of the small employer.

1011 [(12)] (4) No small employer carrier shall, directly or indirectly,
1012 enter into any contract, agreement or arrangement with a producer
1013 that provides for or results in the compensation paid to a producer for
1014 the sale of a health benefit plan to be varied because of the health
1015 status, claims experience, industry, occupation or geographic area of
1016 the small employer. A small employer carrier shall provide reasonable
1017 compensation, as provided under the plan of operation of the
1018 program, to a producer, if any, for the sale of a [special or a small
1019 employer] health care plan. No small employer carrier shall terminate,
1020 fail to renew or limit its contract or agreement of representation with a
1021 producer for any reason related to the health status, claims experience,
1022 occupation, or geographic location of the small employers placed by
1023 the producer with the small employer carrier.

1024 [(13)] (5) No small employer carrier or producer shall induce or
1025 otherwise encourage a small employer to separate or otherwise
1026 exclude an employee from health coverage or benefits provided in
1027 connection with the employee's employment.

1028 [(14)] Denial by a small employer carrier of an application for
1029 coverage from a small employer shall be in writing and shall state the
1030 reasons for the denial.]

1031 [(15)] (6) No small employer carrier or producer shall disclose (A) to
1032 a small employer the fact that any or all of the eligible employees of
1033 such small employer have been or will be reinsured with the pool, or
1034 (B) to any eligible employee or dependent the fact that he has been or
1035 will be reinsured with the pool.

1036 [(16)] (7) If a small employer carrier enters into a contract,
1037 agreement or other arrangement with another party to provide
1038 administrative, marketing or other services related to the offering of

1039 health benefit plans to small employers in this state, the other party
1040 shall be subject to the provisions of this section.

1041 [(17)] (8) The commissioner may adopt regulations in accordance
1042 with the provisions of chapter 54 setting forth additional standards to
1043 provide for the fair marketing and broad availability of health benefit
1044 plans to small employers.

1045 [(18) Each small employer carrier shall maintain at its principal
1046 place of business a complete and detailed description of its rating
1047 practices and renewal underwriting practices, including information
1048 and documentation that demonstrates that its rating methods and
1049 practices are based upon commonly accepted actuarial assumptions
1050 and are in accordance with sound actuarial principles. Each small
1051 employer carrier shall file with the commissioner annually, on or
1052 before March fifteenth, an actuarial certification certifying that the
1053 carrier is in compliance with this part and that the rating methods have
1054 been derived using recognized actuarial principles consistent with the
1055 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
1056 shall be in a form and manner and shall contain such information as
1057 determined by the commissioner. A copy of the certification shall be
1058 retained by the small employer carrier at its principal place of
1059 business. Any information and documentation described in this
1060 subdivision but not subject to the filing requirement shall be made
1061 available to the commissioner upon his request. Except in cases of
1062 violations of sections 38a-564 to 38a-573, inclusive, the information
1063 shall be considered proprietary and trade secret information and shall
1064 not be subject to disclosure by the commissioner to persons outside of
1065 the department except as agreed to by the small employer carrier or as
1066 ordered by a court of competent jurisdiction.

1067 (19) The commissioner may suspend all or any part of this section
1068 relating to the premium rates applicable to one or more small
1069 employers for one or more rating periods upon a filing by the small
1070 employer carrier and a finding by the commissioner that either the

1071 suspension is reasonable in light of the financial condition of the
1072 carrier or that the suspension would enhance the efficiency and
1073 fairness of the marketplace for small employer health insurance.

1074 (20) For rating periods commencing prior to July 1, 1995, a small
1075 employer carrier shall quote premium rates to any small employer
1076 within thirty days after receipt by the carrier of such employer's
1077 completed application.]

1078 [(21)] (9) Any violation of subdivisions [(10) to (16)] (3) to (7),
1079 inclusive, of this section and of any regulations established under
1080 subdivision [(17)] (8) of this section shall be an unfair and prohibited
1081 practice under sections 38a-815 to 38a-830, inclusive.

1082 [(22) (A) With respect to plans or arrangements issued pursuant to
1083 subsection (i) of section 5-259, at the option of the Comptroller, the
1084 premium rates charged or offered to small employers purchasing
1085 health insurance shall not be subject to this section, provided (i) the
1086 plan or plans offered or issued cover such small employers as a single
1087 entity and cover not less than three thousand employees on the date
1088 issued, (ii) each small employer is charged or offered the same
1089 premium rate with respect to each employee and dependent, and (iii)
1090 the plan or plans are written on a guaranteed issue basis.

1091 (B) With respect to plans or arrangements issued by an association
1092 group plan, at the option of the administrator of the association group
1093 plan, the premium rates charged or offered to small employers
1094 purchasing health insurance shall not be subject to this section,
1095 provided (i) the plan or plans offered or issued cover such small
1096 employers as a single entity and cover not less than three thousand
1097 employees on the date issued, (ii) each small employer is charged or
1098 offered the same premium rate with respect to each employee and
1099 dependent, and (iii) the plan or plans are written on a guaranteed issue
1100 basis. In addition, such association group (I) shall be a bona fide group
1101 as set forth in the Employee Retirement and Security Act of 1974, (II)

1102 shall not be formed for the purposes of fictitious grouping, as defined
1103 in section 38a-827, and (III) shall not issue any plan that shall cause
1104 undue disruption in the insurance marketplace, as determined by the
1105 commissioner.]

1106 Sec. 8. Subparagraph (B) of subdivision (2) of section 38a-567 of the
1107 general statutes, as amended by section 7 of this act, is repealed and
1108 the following is substituted in lieu thereof (*Effective January 1, 2015*):

1109 (B) (i) With respect to nongrandfathered plans issued to small
1110 employers, the premium rates charged or offered shall be established
1111 on the basis of a single pool of all nongrandfathered plans, adjusted to
1112 reflect one or more of the following classifications:

1113 (I) Age, in accordance with a uniform age rating curve established
1114 by the commissioner;

1115 (II) Geographic area, as defined by the commissioner; [.]

1116 (III) Tobacco use, except that such rate may not vary by a ratio of
1117 greater than 1.5 to 1.0 and may only be applied with respect to
1118 individuals who may legally use tobacco under state and federal law.
1119 For purposes of this subparagraph, "tobacco use" means the use of
1120 tobacco products four or more times per week on average within a
1121 period not longer than the six months immediately preceding.
1122 "Tobacco use" does not include the religious or ceremonial use of
1123 tobacco.

1124 (ii) Total premium rates for family coverage for nongrandfathered
1125 plans shall be determined by adding the premiums for each individual
1126 family member, except that with respect to family members under
1127 twenty-one years of age, the premiums for only the three oldest
1128 covered children shall be taken into account in determining the total
1129 premium rate for such family.

1130 (iii) Premium rates for employees and dependents for

1131 nongrandfathered plans shall be calculated for each covered individual
1132 and premium rates for the small employer group shall be calculated by
1133 totaling the premiums attributable to each covered individual.

1134 (iv) Premium rates for any given nongrandfathered plan may vary
1135 by actuarially justified amounts to reflect the plan's provider network
1136 and administrative expense differences that can be reasonably
1137 allocated to such plan.

1138 Sec. 9. Section 38a-569 of the general statutes is repealed and the
1139 following is substituted in lieu thereof (*Effective from passage*):

1140 (a) (1) There is established a nonprofit entity to be known as the
1141 "Connecticut Small Employer Health Reinsurance Pool". All insurers
1142 issuing health insurance in this state and insurance arrangements
1143 providing health plan benefits in this state on and after July 1, 1990,
1144 shall be members of the pool.

1145 (2) On or before July 15, 1990, the commissioner shall give notice to
1146 all insurers and insurance arrangements of the time and place for the
1147 initial organizational meeting, which shall take place by September 1,
1148 1990. The members shall select the initial board, subject to approval by
1149 the commissioner. The board shall consist of at least five and not more
1150 than nine representatives of members. There shall be no more than two
1151 members of the board representing any one insurer or insurance
1152 arrangement. In determining voting rights at the organizational
1153 meeting, each member shall be entitled to vote in person or by proxy.
1154 The vote shall be weighted based upon net health insurance premium
1155 derived from this state in the previous calendar year. To the extent
1156 possible, at least one-third of the members of the board shall be
1157 domestic insurance companies and at least two-thirds of the members
1158 of the board shall be small employer carriers. At least one member of
1159 the board shall be a health care center and at least one member shall be
1160 a small employer carrier with less than one hundred million dollars in
1161 net small employer health insurance premium in this state. The

1162 Insurance Commissioner shall be an ex-officio member of the board.
1163 The net premium amount shall be adjusted by the board periodically
1164 for health care cost inflation. In approving selection of the board, the
1165 commissioner shall assure that all members are fairly represented. The
1166 membership of all boards subsequent to the initial board shall, to the
1167 extent possible, reflect the same distribution of representation as is
1168 described in this subdivision.

1169 (3) If the initial board is not elected at the organizational meeting,
1170 the commissioner shall appoint the initial board within fifteen days of
1171 the organizational meeting.

1172 (4) Within ninety days after the appointment of such initial board,
1173 the board shall submit to the commissioner a plan of operation and
1174 thereafter any amendments thereto necessary or suitable to assure the
1175 fair, reasonable and equitable administration of the pool. The
1176 commissioner shall, after notice and hearing, approve the plan of
1177 operation provided he determines it to be suitable to assure the fair,
1178 reasonable and equitable administration of the pool, and provides for
1179 the sharing of pool gains or losses on an equitable proportionate basis
1180 in accordance with the provisions of subsection (d) of this section,
1181 revision of 1958, revised to January 1, 2013. The plan of operation shall
1182 become effective upon approval in writing by the commissioner
1183 consistent with the date on which the coverage under this section shall
1184 be made available. If the board fails to submit a suitable plan of
1185 operation within one hundred eighty days after its appointment, or at
1186 any time thereafter fails to submit suitable amendments to the plan of
1187 operation, the commissioner shall, after notice and hearing, adopt and
1188 promulgate a plan of operation or amendments, as appropriate. The
1189 commissioner shall amend any plan adopted by him, as necessary, at
1190 the time a plan of operation is submitted by the board and approved
1191 by the commissioner.

1192 (5) [The] On and after the effective date of this section, the plan of
1193 operation shall establish procedures for: (A) Handling and accounting

1194 of assets and moneys of the pool, and for an annual fiscal reporting to
1195 the commissioner; (B) filling vacancies on the board, subject to the
1196 approval of the commissioner; (C) selecting an administrator and
1197 setting forth the powers and duties of the administrator; (D) reinsuring
1198 risks; [in accordance with the provisions of this section;] (E) collecting
1199 assessments from all members to provide for claims reinsured by the
1200 pool and for administrative expenses incurred or estimated to be
1201 incurred during the period for which the assessment is made; and (F)
1202 any additional matters at the discretion of the board.

1203 (6) The pool shall have the general powers and authority granted
1204 under the laws of Connecticut to insurance companies licensed to
1205 transact health insurance and, in addition thereto, the specific
1206 authority to: (A) Enter into contracts as are necessary or proper to
1207 carry out the provisions and purposes of this section, including the
1208 authority, with the approval of the commissioner, to enter into
1209 contracts with programs of other states for the joint performance of
1210 common functions, or with persons or other organizations for the
1211 performance of administrative functions; (B) sue or be sued, including
1212 taking any legal actions necessary or proper for recovery of any
1213 assessments for, on behalf of, or against members; (C) take such legal
1214 action as necessary to avoid the payment of improper claims against
1215 the pool; (D) define the array of health coverage products for which
1216 reinsurance will be provided, and to issue reinsurance policies, in
1217 accordance with the requirements of this section; (E) establish rules,
1218 conditions and procedures pertaining to the reinsurance of members'
1219 risks by the pool; (F) establish appropriate rates, rate schedules, rate
1220 adjustments, rate classifications and any other actuarial functions
1221 appropriate to the operation of the pool; (G) assess members in
1222 accordance with the provisions of subsection (e) of this section, and to
1223 make advance interim assessments as may be reasonable and
1224 necessary for organizational and interim operating expenses. Any such
1225 interim assessments shall be credited as offsets against any regular
1226 assessments due following the close of the fiscal year; (H) appoint from

1227 among members appropriate legal, actuarial and other committees as
1228 necessary to provide technical assistance in the operation of the pool,
1229 policy and other contract design, and any other function within the
1230 authority of the pool; and (I) borrow money to effect the purposes of
1231 the pool. Any notes or other evidence of indebtedness of the pool not
1232 in default shall be legal investments for insurers and may be carried as
1233 admitted assets.

1234 (b) Any member whose health insurance plan is subject to section
1235 38a-567, as amended by this act, may reinsure with the pool coverage
1236 of an eligible employee of a small employer [,] or any dependent of
1237 such an employee. [, except that no member may reinsure with the
1238 pool coverage of an eligible employee of a small employer, or any
1239 dependent of such an employee, whose premium rates are not subject
1240 to section 38a-567 pursuant to subdivision (22) of section 38a-567. Any
1241 reinsurance placed with the pool from the date of the establishment of
1242 the pool regarding the coverage of an eligible employee of a small
1243 employer, or any dependent of such an employee shall be provided as
1244 follows:]

1245 [(1) (A) With respect to a special health care plan or a small
1246 employer health care plan, the pool shall reinsure the level of coverage
1247 provided; (B) with respect to other plans, the pool shall reinsure the
1248 level of coverage provided up to, but not exceeding, the level of
1249 coverage provided in a small employer health care plan or the
1250 actuarial equivalent thereof as defined and authorized by the board;
1251 and (C) in either case, no reinsurance may be provided in any calendar
1252 year for a reinsured employee or dependent until five thousand dollars
1253 in benefit payments have been made for services provided during that
1254 calendar year for that reinsured employee or dependent, which
1255 payments would have been reimbursed through said reinsurance in
1256 the absence of the annual five-thousand-dollar deductible. The amount
1257 of the deductible shall be periodically reviewed by the board and may
1258 be adjusted for appropriate factors as determined by the board;

1259 (2) With respect to eligible employees, and their dependents,
1260 coverage may be reinsured: (A) Within such period of time after the
1261 commencement of their coverage under the plan as may be authorized
1262 by the board, or (B) commencing January 1, 1992, on the first plan
1263 anniversary after the employer's coverage has been in effect with the
1264 small employer carrier for a period of three years, and every third plan
1265 anniversary thereafter, provided, commencing May 1, 1994,
1266 reinsurance pursuant to this subparagraph shall only be permitted
1267 with respect to eligible employees and their dependents of a small
1268 employer which has no more than two eligible employees as of the
1269 applicable anniversary;

1270 (3) Reinsurance coverage may be terminated for each reinsured
1271 employee or dependent on any plan anniversary;

1272 (4) Reinsurance of newborn dependents shall be allowed only if the
1273 mother of any such dependent is reinsured as of the date of birth of
1274 such child, and all newborn dependents of reinsured persons shall be
1275 automatically reinsured as of their date of birth; and

1276 (5) Notwithstanding the provisions of subparagraph (A) of
1277 subdivision (2) of this subsection: (A) Coverage for eligible employees
1278 and their dependents provided under a group policy covering two or
1279 more small employers shall not be eligible for reinsurance when such
1280 coverage is discontinued and replaced by a group policy of another
1281 carrier covering two or more small employers, unless coverage for
1282 such eligible employees or dependents was reinsured by the prior
1283 carrier; and (B) at the time coverage is assumed for such group by a
1284 succeeding carrier, such carrier shall notify the pool of its intention to
1285 provide coverage for such group and shall identify the employees and
1286 dependents whose coverage will continue to be reinsured. The time
1287 limitations for providing such notice shall be established by the pool.

1288 (c) Except as provided in subsection (d) of this section, premium
1289 rates charged for reinsurance by the pool shall be established at the

1290 following percentages of the rate established by the pool for that
1291 classification or group with similar characteristics and coverage:

1292 (1) One hundred fifty per cent, with respect to all of the eligible
1293 employees, and their dependents, of a small employer, all of whose
1294 coverage is reinsured in accordance with subdivision (2) of subsection
1295 (b) of this section; and

1296 (2) Five hundred per cent, with respect to an eligible employee or
1297 dependent who is individually reinsured in accordance with
1298 subdivision (2) of subsection (b) of this section and is not reinsured
1299 with all eligible employees of an employer and their dependents.

1300 (d) Premium rates charged for reinsurance by the pool to a health
1301 care center which is approved by the Secretary of Health and Human
1302 Services as a health maintenance organization pursuant to 42 USC 300
1303 et seq., and as such is subject to requirements that limit the amount of
1304 risk that may be ceded to the pool, may be modified by the board, if
1305 appropriate, to reflect the portion of risk that may be ceded to the
1306 pool.]

1307 [(e)] (c) (1) Following the close of each fiscal year, the administrator
1308 shall determine the net premiums, the pool expenses of administration
1309 and the incurred losses for the year, taking into account investment
1310 income and other appropriate gains and losses. For purposes of this
1311 section, health insurance premiums earned by insurance arrangements
1312 shall be established by adding paid health losses and administrative
1313 expenses of the insurance arrangement. Health insurance premiums
1314 and benefits paid by a member that are less than an amount
1315 determined by the board to justify the cost of collection shall not be
1316 considered for purposes of determining assessments. For purposes of
1317 this subsection, "net premiums" means health insurance premiums,
1318 less administrative expense allowances.

1319 (2) Any net loss for the year shall be recouped by assessments of
1320 members.

1321 (A) Assessments shall first be apportioned by the board among all
1322 members in proportion to their respective shares of the total health
1323 insurance premiums earned in this state from health insurance plans
1324 and insurance arrangements covering small employers during the
1325 calendar year coinciding with or ending during the fiscal year of the
1326 pool, or on any other equitable basis reflecting coverage of small
1327 employers as may be provided in the plan of operations. An
1328 assessment shall be made pursuant to this subparagraph against a
1329 health care center, [which] that is approved by the Secretary of Health
1330 and Human Services as a health maintenance organization pursuant to
1331 42 USC 300e et seq., subject to an assessment adjustment formula
1332 adopted by the board and approved by the commissioner for such
1333 health care centers [which] that recognizes the restrictions imposed on
1334 such health care centers by federal law. Such adjustment formula shall
1335 be adopted by the board and approved by the commissioner prior to
1336 the first anniversary of the pool's operation.

1337 (B) If such net loss is not recouped before assessments totaling five
1338 per cent of such premiums from plans and arrangements covering
1339 small employers have been collected, additional assessments shall be
1340 apportioned by the board among all members in proportion to their
1341 respective shares of the total health insurance premiums earned in this
1342 state from other individual and group plans and arrangements,
1343 exclusive of any individual Medicare supplement policies as defined in
1344 section 38a-495 during such calendar year.

1345 (C) Notwithstanding the provisions of this subdivision, the
1346 assessments to any one member under subparagraph (A) or (B) of this
1347 subdivision shall not exceed forty per cent of the total assessment
1348 under each subparagraph for the first fiscal year of the pool's operation
1349 and fifty per cent of the total assessment under each subparagraph for
1350 the second fiscal year. Any amounts abated pursuant to this
1351 subparagraph shall be assessed against the other members in a manner
1352 consistent with the basis for assessments set forth in this subdivision.

1353 (3) If assessments exceed actual losses and administrative expenses
1354 of the pool, the excess shall be held at interest and used by the board to
1355 offset future losses or to reduce pool premiums. As used in this
1356 subsection, "future losses" includes reserves for incurred but not
1357 reported claims.

1358 (4) Each member's proportion of participation in the pool shall be
1359 determined annually by the board based on annual statements and
1360 other reports deemed necessary by the board and filed by the member
1361 with it. Insurance arrangements shall report to the board claims
1362 payments made and administrative expenses incurred in this state on
1363 an annual basis on a form prescribed by the commissioner.

1364 (5) Provision shall be made in the plan of operation for the
1365 imposition of an interest penalty for late payment of assessments.

1366 (6) The board may defer, in whole or in part, the assessment of a
1367 health care center if, in the opinion of the board: (A) Payment of the
1368 assessment would endanger the ability of the health care center to
1369 fulfill its contractual obligations, or (B) in accordance with standards
1370 included in the plan of operation, the health care center has written,
1371 and reinsured in their entirety, a disproportionate number of special
1372 health care plans. In the event an assessment against a health care
1373 center is deferred in whole or in part, the amount by which such
1374 assessment is deferred may be assessed against the other members in a
1375 manner consistent with the basis for assessments set forth in this
1376 subsection. The health care center receiving such deferment shall
1377 remain liable to the pool for the amount deferred. The board may
1378 attach appropriate conditions to any such deferment.

1379 [(f) (1) Neither the] (d) (1) The participation in the pool as members,
1380 the establishment of rates, forms or procedures [nor] or any other joint
1381 or collective action required by this section shall not be the basis of any
1382 legal action, criminal or civil liability or penalty against the pool or any
1383 of its members.

1384 (2) Any person or member made a party to any action, suit or
1385 proceeding because the person or member served on the board or on a
1386 committee or was an officer or employee of the pool shall be held
1387 harmless and be indemnified by the program against all liability and
1388 costs, including the amounts of judgments, settlements, fines or
1389 penalties, and expenses and reasonable attorney's fees incurred in
1390 connection with the action, suit or proceeding. The indemnification
1391 shall not be provided on any matter in which the person or member is
1392 finally adjudged in the action, suit or proceeding to have committed a
1393 breach of duty involving gross negligence, dishonesty, wilful
1394 misfeasance or reckless disregard of the responsibilities of office. Costs
1395 and expenses of the indemnification shall be prorated and paid for by
1396 all members. The Insurance Commissioner may retain actuarial
1397 consultants necessary to carry out said commissioner's responsibilities
1398 pursuant to [sections] this section, section 38a-564, as amended by this
1399 act, [to 38a-572, inclusive] 38a-566, as amended by this act, or 38a-567,
1400 as amended by this act, and such expenses shall be paid by the pool
1401 established in this section.

1402 Sec. 10. Section 38a-574 of the general statutes is repealed and the
1403 following is substituted in lieu thereof (*Effective from passage*):

1404 (a) [On or before July 1, 1993, the] The board of directors of the
1405 Connecticut Small Employer Health Reinsurance Pool shall establish,
1406 subject to the approval of the Insurance Commissioner, a standard
1407 [underwriting form] family health statement for use by small employer
1408 carriers [for medical underwriting of health insurance plans and
1409 insurance arrangements covering small employers, as defined in
1410 section 38a-564. Within] to determine whether to cede lives to the
1411 reinsurance pool. Not later than ninety days after approval by the
1412 Insurance Commissioner of the [standard underwriting form] family
1413 health statement, the board shall require every small employer carrier,
1414 as a condition of transacting such business in this state, to use the form
1415 for [medical underwriting of] such plans and arrangements.

1416 (b) The [form] statement may be amended from time to time as the
1417 board deems necessary, subject to the approval of the Insurance
1418 Commissioner.

1419 Sec. 11. Section 38a-537 of the general statutes is repealed and the
1420 following is substituted in lieu thereof (*Effective from passage*):

1421 (a) Any individual, partnership, corporation, or unincorporated
1422 association providing group health insurance coverage for its
1423 employees shall furnish each insured employee, upon cancellation or
1424 discontinuation of such health insurance, notice of the cancellation or
1425 discontinuation of such insurance. The notice shall be mailed or
1426 delivered to the insured employee not less than fifteen days next
1427 preceding the effective date of cancellation or discontinuation. Any
1428 individual or any such entity that fails to provide timely notice shall be
1429 fined not more than two thousand dollars for each violation. The Labor
1430 Commissioner shall have the authority to assess all such fines. This
1431 section shall apply to any such individual, partnership, corporation or
1432 unincorporated association that substitutes one policy providing
1433 group health insurance coverage for another such policy with no
1434 interruption in coverage.

1435 (b) If any individual or any such entity fails to furnish notice
1436 pursuant to subsection (a) of this section, the individual or entity shall
1437 be liable for benefits to the same extent as the insurer, hospital or
1438 medical service corporation or health care center would have been
1439 liable if coverage had not been cancelled or discontinued.

1440 (c) Any individual, partnership, corporation, or unincorporated
1441 association which makes deductions from an employee's wages for
1442 group health insurance coverage and fails to procure such coverage
1443 shall be liable for benefits to the same extent as the insurer, hospital or
1444 medical service corporation or health care center would have been
1445 liable if coverage had been procured. If any corporation makes
1446 deductions from an employee's wages for group health insurance

1447 coverage and fails to procure such coverage, any officer of the
1448 corporation responsible for procuring such coverage for employees
1449 who wilfully failed to procure such coverage shall be personally liable
1450 for benefits to the same extent as the insurer, hospital or medical
1451 service corporation or health care center would have been liable if
1452 coverage had been procured, provided that personal liability shall only
1453 be imposed against the officer in the event that an amount owed an
1454 employee due to the officer's failure cannot otherwise be collected
1455 from the corporation itself.

1456 [(d) Whenever an employer ceases doing business, any terminated
1457 employee whose group health insurance was discontinued on or
1458 before the date of termination of employment and who did not receive
1459 notice of such discontinuation pursuant to subsection (a) of this section
1460 shall be eligible for ninety days from the date of discontinuation to
1461 purchase as a conversion privilege an individual comprehensive health
1462 care plan for himself and any dependents covered by the discontinued
1463 group health insurance plan from the former insurer, hospital or
1464 medical service corporation, health care center or the Health
1465 Reinsurance Association, if any insurer is not issuing such coverage,
1466 with coverage retroactive to the date of discontinuation. The employee
1467 shall pay the premiums for the period of retroactive coverage. No
1468 retroactive coverage may be purchased for a period during which the
1469 employee is eligible for benefits under another group plan.]

1470 Sec. 12. Section 38a-512a of the general statutes is repealed and the
1471 following is substituted in lieu thereof (*Effective from passage*):

1472 (a) (1) Each insurer, health care center, hospital service corporation,
1473 medical service corporation, fraternal benefit society or other entity
1474 delivering, issuing for delivery, renewing, amending or continuing a
1475 group health insurance policy in this state that provides coverage of
1476 the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of
1477 section 38a-469 shall provide the option to continue coverage under
1478 each of the following circumstances until the individual is eligible for

1479 other group insurance, except as provided in subparagraphs (C) and
1480 (D) of this subdivision:

1481 (A) Upon layoff, reduction of hours, leave of absence or termination
1482 of employment, other than as a result of death of the employee or as a
1483 result of such employee's "gross misconduct" as that term is used in 29
1484 USC 1163(2), continuation of coverage for such employee and such
1485 employee's covered dependents for a period of thirty months after the
1486 date of such layoff, reduction of hours, leave of absence or termination
1487 of employment, except that if such reduction of hours, leave of absence
1488 or termination of employment results from an employee's eligibility to
1489 receive Social Security income, continuation of coverage for such
1490 employee and such employee's covered dependents until midnight of
1491 the day preceding such person's eligibility for benefits under Title
1492 XVIII of the Social Security Act;

1493 (B) Upon the death of the employee, continuation of coverage for
1494 the covered dependents of such employee for the periods set forth for
1495 such event under federal extension requirements established by the
1496 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1497 as amended from time to time;

1498 (C) Regardless of the employee's or dependent's eligibility for other
1499 group insurance, during an employee's absence due to illness or injury,
1500 continuation of coverage for such employee and such employee's
1501 covered dependents during continuance of such illness or injury or for
1502 up to twelve months from the beginning of such absence;

1503 (D) Regardless of an individual's eligibility for other group
1504 insurance, upon termination of the group policy, coverage for covered
1505 individuals who were totally disabled on the date of termination shall
1506 be continued without premium payment during the continuance of
1507 such disability for a period of twelve calendar months following the
1508 calendar month in which such policy was terminated, provided claim
1509 is submitted for coverage within one year of the termination of such

1510 policy;

1511 (E) The coverage of any covered individual shall terminate: (i) As to
1512 a child, (I) as set forth in section 38a-512b. If on the date specified for
1513 termination of coverage on a child, the child is incapable of self-
1514 sustaining employment by reason of mental or physical handicap and
1515 chiefly dependent upon the employee for support and maintenance,
1516 the coverage on such child shall continue while the plan remains in
1517 force and the child remains in such condition, provided proof of such
1518 handicap is received by such insurer, center, corporation, society or
1519 other entity within thirty-one days of the date on which the child's
1520 coverage would have terminated in the absence of such incapacity.
1521 Such insurer, center, corporation, society or other entity may require
1522 subsequent proof of the child's continued incapacity and dependency
1523 but not more often than once a year thereafter, or (II) for the periods
1524 set forth for such child under federal extension requirements
1525 established by the Consolidated Omnibus Budget Reconciliation Act of
1526 1985, P.L. 99-272, as amended from time to time; (ii) as to the
1527 employee's spouse, at the end of the month following the month in
1528 which a divorce, court-ordered annulment or legal separation is
1529 obtained, whichever is earlier, except that the plan shall provide the
1530 option for said spouse to continue coverage for the periods set forth for
1531 such events under federal extension requirements established by the
1532 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1533 as amended from time to time; and (iii) as to the employee or
1534 dependent who is sixty-five years of age or older, as of midnight of the
1535 day preceding such person's eligibility for benefits under Title XVIII of
1536 the federal Social Security Act;

1537 (F) As to any other event listed as a "qualifying event" in 29 USC
1538 1163, as amended from time to time, continuation of coverage for such
1539 periods set forth for such event in 29 USC 1162, as amended from time
1540 to time, provided such plan may require the individual whose
1541 coverage is to be continued to pay up to the percentage of the
1542 applicable premium as specified for such event in 29 USC 1162, as

1543 amended from time to time.

1544 (2) Any continuation of coverage required by this subsection except
1545 subparagraph (D) or (F) of subdivision (1) of this subsection may be
1546 subject to the requirement, on the part of the individual whose
1547 coverage is to be continued, that such individual contribute that
1548 portion of the premium the individual would have been required to
1549 contribute had the employee remained an active covered employee,
1550 except that the individual may be required to pay up to one hundred
1551 two per cent of the entire premium at the group rate if coverage is
1552 continued in accordance with subparagraph (A), (B) or (E) of
1553 subdivision (1) of this subsection. The employer shall not be legally
1554 obligated by section 38a-505, as amended by this act, or 38a-546 to pay
1555 such premium if not paid timely by the employee.

1556 [(b) The plan shall make available to Connecticut residents, in
1557 addition to any other conversion privilege available, a conversion
1558 privilege under which coverage shall be available immediately upon
1559 termination of coverage under the group policy. The terms and
1560 benefits offered under the conversion benefits shall be at least equal to
1561 the terms and benefits of an individual health insurance policy.]

1562 [(c)] (b) Nothing in this section shall alter or impair existing group
1563 policies which have been established pursuant to an agreement which
1564 resulted from collective bargaining, and the provisions required by
1565 this section shall become effective upon the next regular renewal and
1566 completion of such collective bargaining agreement.

1567 Sec. 13. Subsection (f) of section 5-248a of the 2014 supplement to
1568 the general statutes is repealed and the following is substituted in lieu
1569 thereof (*Effective from passage*):

1570 (f) [Notwithstanding the provisions of subsection (b) of section 38a-
1571 554, the] The state shall pay for the continuation of health insurance
1572 benefits for the employee during any leave of absence taken pursuant
1573 to this section. In order to continue any other health insurance

1574 coverages during such leave, the employee shall contribute that
1575 portion of the premium the employee would have been required to
1576 contribute had the employee remained an active employee during the
1577 leave period.

1578 Sec. 14. Subsection (i) of section 5-259 of the 2014 supplement to the
1579 general statutes is repealed and the following is substituted in lieu
1580 thereof (*Effective from passage*):

1581 (i) The Comptroller may provide for coverage of employees of
1582 municipalities, nonprofit corporations, community action agencies and
1583 small employers and individuals eligible for a health coverage tax
1584 credit, retired members or members of an association for personal care
1585 assistants under the plan or plans procured under subsection (a) of this
1586 section, provided: (1) Participation by each municipality, nonprofit
1587 corporation, community action agency, small employer, eligible
1588 individual, retired member or association for personal care assistants
1589 shall be on a voluntary basis; (2) where an employee organization
1590 represents employees of a municipality, nonprofit corporation,
1591 community action agency or small employer, participation in a plan or
1592 plans to be procured under subsection (a) of this section shall be by
1593 mutual agreement of the municipality, nonprofit corporation,
1594 community action agency or small employer and the employee
1595 organization only and neither party may submit the issue of
1596 participation to binding arbitration except by mutual agreement if
1597 such binding arbitration is available; (3) no group of employees shall
1598 be refused entry into the plan by reason of past or future health care
1599 costs or claim experience; (4) rates paid by the state for its employees
1600 under subsection (a) of this section are not adversely affected by this
1601 subsection; (5) administrative costs to the plan or plans provided
1602 under this subsection shall not be paid by the state; (6) participation in
1603 the plan or plans in an amount determined by the state shall be for the
1604 duration of the period of the plan or plans, or for such other period as
1605 mutually agreed by the municipality, nonprofit corporation,
1606 community action agency, small employer, retired member or

1607 association for personal care assistants and the Comptroller; and (7)
1608 nothing in this section or section 12-202a, 38a-551, as amended by this
1609 act, [38a-553] or 38a-556, as amended by this act, shall be construed as
1610 requiring a participating insurer or health care center to issue
1611 individual policies to individuals eligible for a health coverage tax
1612 credit. The coverage provided under this section may be referred to as
1613 the "Municipal Employee Health Insurance Plan". The Comptroller
1614 may arrange and procure for the employees and eligible individuals
1615 under this subsection health benefit plans that vary from the plan or
1616 plans procured under subsection (a) of this section. Notwithstanding
1617 any provision of part V of chapter 700c, the coverage provided under
1618 this subsection may be offered on either a fully underwritten or risk-
1619 pooled basis at the discretion of the Comptroller. For the purposes of
1620 this subsection, (A) "municipality" means any town, city, borough,
1621 school district, taxing district, fire district, district department of
1622 health, probate district, housing authority, regional work force
1623 development board established under section 31-3k, regional
1624 emergency telecommunications center, tourism district established
1625 under section 32-302, flood commission or authority established by
1626 special act, regional planning agency, transit district formed under
1627 chapter 103a, or the Children's Center established by number 571 of
1628 the public acts of 1969; (B) "nonprofit corporation" means (i) a
1629 nonprofit corporation organized under 26 USC 501 that has a contract
1630 with the state or receives a portion of its funding from a municipality,
1631 the state or the federal government, or (ii) an organization that is tax
1632 exempt pursuant to 26 USC 501(c)(5); (C) "community action agency"
1633 means a community action agency, as defined in section 17b-885; (D)
1634 "small employer" means a small employer, as defined in
1635 [subparagraph (A) of subdivision (4) of] section 38a-564, as amended
1636 by this act; (E) "eligible individuals" or "individuals eligible for a health
1637 coverage tax credit" means individuals who are eligible for the credit
1638 for health insurance costs under Section 35 of the Internal Revenue
1639 Code of 1986, or any subsequent corresponding internal revenue code
1640 of the United States, as from time to time amended, in accordance with

1641 the Pension Benefit Guaranty Corporation; [and Trade Adjustment
1642 Assistance programs of the Trade Act of 2002 (P.L. 107-210);] (F)
1643 "association for personal care assistants" means an organization
1644 composed of personal care attendants who are employed by recipients
1645 of service (i) under the home-care program for the elderly under
1646 section 17b-342, (ii) under the personal care assistance program under
1647 section 17b-605a, (iii) in an independent living center pursuant to
1648 sections 17b-613 to 17b-615, inclusive, or (iv) under the program for
1649 individuals with acquired brain injury as described in section 17b-
1650 260a; and (G) "retired members" means individuals eligible for a
1651 retirement benefit from the Connecticut municipal employees'
1652 retirement system.

1653 Sec. 15. Subsection (i) of section 5-259 of the 2014 supplement to the
1654 general statutes, as amended by section 266 of public act 13-247, is
1655 repealed and the following is substituted in lieu thereof (*Effective*
1656 *January 1, 2015*):

1657 (i) The Comptroller may provide for coverage of employees of
1658 municipalities, nonprofit corporations, community action agencies and
1659 small employers and individuals eligible for a health coverage tax
1660 credit, retired members or members of an association for personal care
1661 assistants under the plan or plans procured under subsection (a) of this
1662 section, provided: (1) Participation by each municipality, nonprofit
1663 corporation, community action agency, small employer, eligible
1664 individual, retired member or association for personal care assistants
1665 shall be on a voluntary basis; (2) where an employee organization
1666 represents employees of a municipality, nonprofit corporation,
1667 community action agency or small employer, participation in a plan or
1668 plans to be procured under subsection (a) of this section shall be by
1669 mutual agreement of the municipality, nonprofit corporation,
1670 community action agency or small employer and the employee
1671 organization only and neither party may submit the issue of
1672 participation to binding arbitration except by mutual agreement if
1673 such binding arbitration is available; (3) no group of employees shall

1674 be refused entry into the plan by reason of past or future health care
1675 costs or claim experience; (4) rates paid by the state for its employees
1676 under subsection (a) of this section are not adversely affected by this
1677 subsection; (5) administrative costs to the plan or plans provided
1678 under this subsection shall not be paid by the state; (6) participation in
1679 the plan or plans in an amount determined by the state shall be for the
1680 duration of the period of the plan or plans, or for such other period as
1681 mutually agreed by the municipality, nonprofit corporation,
1682 community action agency, small employer, retired member or
1683 association for personal care assistants and the Comptroller; and (7)
1684 nothing in this section or section 12-202a, 38a-551, as amended by this
1685 act, [38a-553] or 38a-556, as amended by this act, shall be construed as
1686 requiring a participating insurer or health care center to issue
1687 individual policies to individuals eligible for a health coverage tax
1688 credit. The coverage provided under this section may be referred to as
1689 the "Municipal Employee Health Insurance Plan". The Comptroller
1690 may arrange and procure for the employees and eligible individuals
1691 under this subsection health benefit plans that vary from the plan or
1692 plans procured under subsection (a) of this section. Notwithstanding
1693 any provision of part V of chapter 700c, the coverage provided under
1694 this subsection may be offered on either a fully underwritten or risk-
1695 pooled basis at the discretion of the Comptroller. For the purposes of
1696 this subsection, (A) "municipality" means any town, city, borough,
1697 school district, taxing district, fire district, district department of
1698 health, probate district, housing authority, regional work force
1699 development board established under section 31-3k, regional
1700 emergency telecommunications center, tourism district established
1701 under section 32-302, flood commission or authority established by
1702 special act, regional council of governments, transit district formed
1703 under chapter 103a, or the Children's Center established by number
1704 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a
1705 nonprofit corporation organized under 26 USC 501 that has a contract
1706 with the state or receives a portion of its funding from a municipality,
1707 the state or the federal government, or (ii) an organization that is tax

1708 exempt pursuant to 26 USC 501(c)(5); (C) "community action agency"
1709 means a community action agency, as defined in section 17b-885; (D)
1710 "small employer" means a small employer, as defined in
1711 [subparagraph (A) of subdivision (4) of] section 38a-564, as amended
1712 by this act; (E) "eligible individuals" or "individuals eligible for a health
1713 coverage tax credit" means individuals who are eligible for the credit
1714 for health insurance costs under Section 35 of the Internal Revenue
1715 Code of 1986, or any subsequent corresponding internal revenue code
1716 of the United States, as from time to time amended, in accordance with
1717 the Pension Benefit Guaranty Corporation; [and Trade Adjustment
1718 Assistance programs of the Trade Act of 2002 (P. L. 107-210);] (F)
1719 "association for personal care assistants" means an organization
1720 composed of personal care attendants who are employed by recipients
1721 of service (i) under the home-care program for the elderly under
1722 section 17b-342, (ii) under the personal care assistance program under
1723 section 17b-605a, (iii) in an independent living center pursuant to
1724 sections 17b-613 to 17b-615, inclusive, or (iv) under the program for
1725 individuals with acquired brain injury as described in section 17b-
1726 260a; and (G) "retired members" means individuals eligible for a
1727 retirement benefit from the Connecticut municipal employees'
1728 retirement system.

1729 Sec. 16. Subdivision (7) of section 12-201 of the general statutes is
1730 repealed and the following is substituted in lieu thereof (*Effective from*
1731 *passage*):

1732 (7) "Gross direct premiums" means all receipts of premiums from
1733 policyholders and applicants for policies, whether received in the form
1734 of money or other valuable consideration, but excluding annuity
1735 premiums and considerations and premiums received for reinsurances
1736 assumed from other insurance companies; [and premiums received
1737 after July 1, 1990, and before January 1, 1995, for any special health
1738 care plan, as defined in section 38a-564;]

1739 Sec. 17. Subsection (c) of section 12-211 of the general statutes is

1740 repealed and the following is substituted in lieu thereof (*Effective from*
1741 *passage*):

1742 (c) The provisions of this section shall not apply to ad valorem taxes
1743 on real or personal property, personal income taxes, fees for agents'
1744 licenses, special purpose assessments imposed in connection with
1745 particular kinds of insurance including, but not limited to, workers'
1746 compensation assessments and Insurance Guaranty Association Fund
1747 assessments, or to premium taxes on special health care plans as
1748 defined in [section] sections 38a-564, revision of 1958, revised to
1749 January 1, 2013, and 38a-551, as amended by this act, except in the case
1750 where another state or foreign country imposes upon Connecticut
1751 domiciled insurers retaliatory charges for such taxes, fees or
1752 assessments.

1753 Sec. 18. Section 12-212a of the general statutes is repealed and the
1754 following is substituted in lieu thereof (*Effective from passage*):

1755 All corporations organized under sections 38a-199 to 38a-209,
1756 inclusive, and 38a-214 to 38a-225, inclusive, shall pay to the
1757 Commissioner of Revenue Services on or before March first, annually,
1758 a charge at the rate of two per cent of the total net direct subscriber
1759 charges [, excluding those net direct subscriber charges received after
1760 July 1, 1990, and before January 1, 1995, from employers for any special
1761 health care plan, as defined in section 38a-564,] received by such
1762 corporation during the next preceding calendar year, which shall be in
1763 addition to any other payment required under section 38a-48. The
1764 charge required under this section and any other payment required
1765 under said section 38a-48 shall be in compensation for the costs and
1766 expenses of regulation by the Insurance Department and all other
1767 governmental services. The provisions of this chapter pertaining to the
1768 filing of returns, declarations, assessment and collection of taxes, and
1769 penalties imposed on domestic insurance companies shall apply with
1770 respect to the charge imposed under this section, provided
1771 corporations subject to the charge imposed under this section shall not

1772 be subject to any tax imposed under this chapter.

1773 Sec. 19. Subsection (e) of section 17b-265 of the general statutes is
1774 repealed and the following is substituted in lieu thereof (*Effective from*
1775 *passage*):

1776 (e) [Notwithstanding the provisions of subsection (c) of section 38a-
1777 553, no] No self-insured plan, group health plan, as defined in Section
1778 607(1) of the Employee Retirement Income Security Act of 1974, service
1779 benefit plan, managed care plan, or any plan offered or administered
1780 by a health care center, pharmacy benefit manager, dental benefit
1781 manager, third-party administrator or other party that is, by statute,
1782 contract or agreement, legally responsible for payment of a claim for a
1783 health care item or service, shall contain any provision that has the
1784 effect of denying or limiting enrollment benefits or excluding coverage
1785 because services are rendered to an insured or beneficiary who is
1786 eligible for or who received medical assistance under this chapter. No
1787 insurer, as defined in section 38a-497a, shall impose requirements on
1788 the state Medicaid agency, which has been assigned the rights of an
1789 individual eligible for Medicaid and covered for health benefits from
1790 an insurer, that differ from requirements applicable to an agent or
1791 assignee of another individual so covered.

1792 Sec. 20. Subsection (c) of section 17b-284 of the general statutes is
1793 repealed and the following is substituted in lieu thereof (*Effective from*
1794 *passage*):

1795 (c) The commissioner may pay under the Medicaid program, within
1796 available appropriations, the premiums for continued health insurance
1797 coverage under an employer's group health insurance plan, pursuant
1798 to section [38a-554] 38a-512a, as amended by this act, for chronically ill
1799 and disabled persons who are no longer employed and would
1800 otherwise be eligible for Medicaid.

1801 Sec. 21. Subdivision (6) of subsection (c) of section 17b-299 of the
1802 general statutes is repealed and the following is substituted in lieu

1803 thereof (*Effective from passage*):

1804 (6) Expiration of the continuation of coverage periods set forth in
1805 section [38a-554] 38a-512a, as amended by this act;

1806 Sec. 22. Subsection (b) of section 17b-611 of the general statutes is
1807 repealed and the following is substituted in lieu thereof (*Effective from*
1808 *passage*):

1809 (b) The contract shall provide the same benefits as are provided
1810 under contracts issued pursuant to sections 38a-505, as amended by
1811 this act, 38a-546, 38a-551, as amended by this act, and 38a-556 to 38a-
1812 559, inclusive, as amended by this act, except mental and nervous
1813 disorders shall be covered in accordance with section 38a-514.

1814 Sec. 23. Subsection (b) of section 19a-7b of the general statutes is
1815 repealed and the following is substituted in lieu thereof (*Effective from*
1816 *passage*):

1817 (b) The commission shall develop the design, administrative,
1818 actuarial and financing details of program initiatives necessary to
1819 attain the goal described in section 19a-7a. [The commission shall
1820 study the experience of the state under the programs and policies
1821 developed pursuant to sections 12-201, 12-211, 12-212a, 17b-277, 17b-
1822 282 to 17b-284, inclusive, 17b-611, 19a-7a to 19a-7d, inclusive,
1823 subsection (a) of 19a-59b, subsection (b) of section 38a-552, subsection
1824 (d) of section 38a-556 and sections 38a-564 to 38a-573, inclusive, and
1825 shall make interim reports to the General Assembly on its findings by
1826 January 15, 1991, and by February 1, 1992, and a final report on such
1827 findings by February 1, 1993.] The commission shall make
1828 recommendations to the General Assembly on any legislation
1829 necessary to further the attainment of the goal described in section 19a-
1830 7a.

1831 Sec. 24. Subsection (a) of section 31-51o of the general statutes is
1832 repealed and the following is substituted in lieu thereof (*Effective from*

1833 *passage*):

1834 (a) Whenever a relocation or closing of a covered establishment
1835 occurs, the employer of the covered establishment shall pay in full for
1836 the continuation of existing group health insurance, no matter where
1837 the group policy was written, issued or delivered, for each affected
1838 employee and his dependents, if covered under the group policy, from
1839 the date of relocation or closing for a period of one hundred twenty
1840 days or until such time as the employee becomes eligible for other
1841 group coverage, whichever is the lesser, provided any right of such
1842 employee and his dependents to a continuation of coverage, as
1843 required by section [38a-538 or 38a-554] 38a-512a, as amended by this
1844 act, shall not be affected by the provisions of this section, and provided
1845 further the period of continued coverage required by said sections
1846 shall not commence until the period of continued coverage established
1847 by this section has terminated.

1848 Sec. 25. Section 38a-472d of the general statutes is repealed and the
1849 following is substituted in lieu thereof (*Effective from passage*):

1850 (a) Not later than January 1, 2006, the Insurance Commissioner, in
1851 consultation with the Commissioner of Social Services and the
1852 Healthcare Advocate, shall develop a comprehensive public education
1853 outreach program to educate health insurance consumers about the
1854 availability and general eligibility requirements of various health
1855 insurance options in this state. The program shall maximize public
1856 information concerning health insurance options in this state and shall
1857 provide for the dissemination of such information on the Insurance
1858 Department's Internet web site.

1859 (b) The information on the department's Internet web site shall
1860 reference the availability and general eligibility requirements of (1)
1861 programs administered by the Department of Social Services,
1862 including, but not limited to, the Medicaid program and the HUSKY
1863 Plan, Part A and Part B, (2) health insurance coverage provided by the

1864 Comptroller under subsection (i) of section 5-259, as amended by this
1865 act, [(3) health insurance coverage available under comprehensive
1866 health care plans issued pursuant to part IV of this chapter, and (4)]
1867 and (3) other health insurance coverage offered through local, state or
1868 federal agencies or through entities licensed in this state. The
1869 commissioner shall update the information on the web site at least
1870 quarterly.

1871 Sec. 26. Section 38a-505 of the general statutes is repealed and the
1872 following is substituted in lieu thereof (*Effective from passage*):

1873 In order to provide reasonable simplification of terms and coverages
1874 of individual health insurance policies, to facilitate public
1875 understanding and comparison, to eliminate provisions [which] that
1876 may be misleading or unreasonably confusing in connection with
1877 either the purchase of such coverage or with the settlement of claims
1878 and to provide for full disclosure in the sale of such coverages:

1879 [(a)] (1) The commissioner shall [issue] adopt regulations, in
1880 accordance with the provisions of chapter 54, to establish specific
1881 standards for policy provisions used in individual health insurance
1882 policies, [but not including group conversion policies, which] that shall
1883 be in addition to and in accordance with sections 38a-80, 38a-321 to
1884 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
1885 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
1886 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
1887 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, and other
1888 applicable laws of this state [which] that may cover the terms of
1889 renewability, initial and subsequent conditions of eligibility,
1890 nonduplication of coverage provisions, coverage of dependents,
1891 termination of insurance, probationary periods, limitations, exceptions,
1892 reductions, elimination periods, requirements for replacements,
1893 recurrent conditions, preexisting conditions [] and the definition of the
1894 terms hospital, accident, sickness, injury, physician, accidental means,
1895 total disability, permanent disability, partial disability, nervous

1896 disorders, guaranteed renewable [,] and noncancellable.

1897 [(b)] (2) The commissioner shall adopt regulations, in accordance
1898 with chapter 54, that specify prohibited policy provisions not
1899 otherwise specifically authorized by statute [which] that, in the
1900 opinion of the commissioner, are unjust, unfair or unfairly
1901 discriminatory to the policyholder, any person insured under the
1902 policy [,] or any beneficiary.

1903 [(c)] (3) The commissioner shall adopt regulations, in accordance
1904 with chapter 54, to establish minimum standards for benefits under
1905 each of the following categories of coverage in individual policies: [,
1906 other than conversion policies issued pursuant to a contractual
1907 conversion privilege under a group policy:] Basic hospital expense
1908 coverage, basic medical-surgical expense coverage, hospital
1909 confinement indemnity coverage, major medical expense coverage,
1910 disability income protection coverage, accident only coverage,
1911 specified accident coverage and specified disease coverage.

1912 [(d)] (4) Nothing in this section shall preclude the issuance of any
1913 policy [which] that combines two or more of the categories of coverage
1914 enumerated in [subsection (c)] subdivision (3) of this section, except
1915 that specified accident coverage shall not be combined with any other
1916 category of coverage. The commissioner shall prescribe the method of
1917 identification of policies based upon coverage provided.

1918 [(e)] (5) No policy shall be delivered or issued for delivery in this
1919 state [which] that does not meet the prescribed minimum standards for
1920 the categories of coverage listed in [subsection (c)] subdivision (3) of
1921 this section, provided nothing in this section shall preclude the
1922 issuance or delivery of any policy [which] that does not meet such
1923 prescribed minimum standards of coverage so long as such policy is
1924 clearly identified as not meeting such prescribed standards.

1925 [(f)] (6) No such policy shall be delivered in this state unless: [(1)]
1926 (A) An outline of coverage described herein accompanies the policy or

1927 [(2)] (B) the outline of coverage described in this section is delivered to
1928 the applicant at the time application is made and acknowledgment of
1929 receipt of certificate of delivery of such outline is provided the carrier
1930 with the application. In the event the policy is issued on a basis other
1931 than that applied for, the outline of coverage properly describing the
1932 policy shall accompany the policy when it is delivered. The outline of
1933 coverage shall include: [(A)] (i) A statement identifying the applicable
1934 category or categories of coverage provided by the policy in
1935 accordance with this section; [(B)] (ii) a description of the principal
1936 benefits and coverage provided in the policy; [(C)] (iii) a statement of
1937 the exceptions, reductions and limitations contained in the policy or
1938 contract; [(D)] (iv) a statement of the renewal provisions including any
1939 reservation by the carrier of a right to change premiums; and [(E)] (v) a
1940 statement that the outline is a summary of the policy issued or applied
1941 for and that the policy should be consulted to determine governing
1942 contractual provisions.

1943 [(g) Notwithstanding the provisions of sections 38a-80, 38a-321 to
1944 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
1945 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
1946 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
1947 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, if a carrier
1948 elects to use a simplified application form, with or without any
1949 questions as to the applicant's health at the time of application, but
1950 without any questions concerning the insured's health history or
1951 medical treatment history, the policy shall cover loss developing after
1952 twelve months from any preexisting condition not specifically
1953 excluded from coverage by the terms of the policy and, except as so
1954 provided, the policy shall not include wording that would permit a
1955 defense based upon preexisting conditions.]

1956 [(h)] (7) Regulations promulgated pursuant to this section shall
1957 specify an effective date applicable to policy and benefit riders
1958 delivered or issued for delivery in this state on and after such effective
1959 date [which] that shall not be less than one hundred eighty days after

1960 the date of adoption or promulgation.

1961 Sec. 27. Section 38a-573 of the general statutes is repealed and the
1962 following is substituted in lieu thereof (*Effective from passage*):

1963 If any provision of [sections] section 38a-564, as amended by this
1964 act, [to 38a-572, inclusive] 38a-566, as amended by this act, 38a-567, as
1965 amended by this act, or 38a-569, as amended by this act, is held
1966 invalid, the invalidity shall not affect other provisions of said sections
1967 [which] that can be given effect without the invalid provisions.

1968 Sec. 28. Section 38a-476 of the general statutes is repealed and the
1969 following is substituted in lieu thereof (*Effective from passage*):

1970 (a) [(1)] For the purposes of this section: [, "health]

1971 (1) "Health insurance plan" means any hospital and medical expense
1972 incurred policy, hospital or medical service plan contract and health
1973 care center subscriber contract. [and] "Health insurance plan" does not
1974 include (A) short-term health insurance issued on a nonrenewable
1975 basis with a duration of six months or less, accident only, credit,
1976 dental, vision, Medicare supplement, long-term care or disability
1977 insurance, hospital indemnity coverage, coverage issued as a
1978 supplement to liability insurance, insurance arising out of a workers'
1979 compensation or similar law, automobile medical payments insurance,
1980 or insurance under which beneficiaries are payable without regard to
1981 fault and which is statutorily required to be contained in any liability
1982 insurance policy or equivalent self-insurance, or (B) policies of
1983 specified disease or limited benefit health insurance, provided that the
1984 carrier offering such policies files on or before March first of each year
1985 a certification with the Insurance Commissioner that contains the
1986 following: (i) A statement from the carrier certifying that such policies
1987 are being offered and marketed as supplemental health insurance and
1988 not as a substitute for hospital or medical expense insurance; (ii) a
1989 summary description of each such policy including the average annual
1990 premium rates, or range of premium rates in cases where premiums

1991 vary by age, gender or other factors, charged for such policies in the
1992 state; and (iii) in the case of a policy that is described in this
1993 subparagraph and that is offered for the first time in this state on or
1994 after October 1, 1993, the carrier files with the commissioner the
1995 information and statement required in this subparagraph at least thirty
1996 days prior to the date such policy is issued or delivered in this state.

1997 (2) "Insurance arrangement" means any "multiple employer welfare
1998 arrangement", as defined in Section 3 of the Employee Retirement
1999 Income Security Act of 1974, [(ERISA),] as amended from time to time,
2000 except for any such arrangement [which] that is fully insured within
2001 the meaning of Section 514(b)(6) of said act, as amended from time to
2002 time.

2003 (3) "Preexisting conditions provision" means a policy provision
2004 [which] that limits or excludes benefits relating to a condition based on
2005 the fact that the condition was present before the effective date of
2006 coverage, for which any medical advice, diagnosis, care or treatment
2007 was recommended or received before such effective date. Routine
2008 follow-up care to determine whether a breast cancer has reoccurred in
2009 a person who has been previously determined to be breast cancer free
2010 shall not be considered as medical advice, diagnosis, care or treatment
2011 for purposes of this section unless evidence of breast cancer is found
2012 during or as a result of such follow-up. Genetic information shall not
2013 be treated as a condition in the absence of a diagnosis of the condition
2014 related to such information. Pregnancy shall not be considered a
2015 preexisting condition.

2016 [(4) "Qualifying coverage" means (A) any group health insurance
2017 plan, insurance arrangement or self-insured plan, (B) Medicare or
2018 Medicaid, or (C) an individual health insurance plan that provides
2019 benefits which are actuarially equivalent to or exceeding the benefits
2020 provided under the small employer health care plan, as defined in
2021 subdivision (12) of section 38a-564, whether issued in this state or any
2022 other state.]

2023 [(5)] (4) "Applicable waiting period" means the period of time
2024 imposed by the group policyholder or contractholder before an
2025 individual is eligible for participating in the group policy or contract.

2026 (b) (1) No group health insurance plan or insurance arrangement
2027 shall impose a preexisting conditions provision [that excludes
2028 coverage for (A) individuals eighteen years of age and younger, or (B)
2029 a period beyond twelve months following the insured's effective date
2030 of coverage. Any preexisting conditions provision shall only relate to
2031 conditions, whether physical or mental, for which medical advice,
2032 diagnosis or care or treatment was recommended or received during
2033 the six months immediately preceding the effective date of coverage]
2034 on any individual.

2035 (2) No individual health insurance plan or insurance arrangement
2036 shall impose a preexisting conditions provision [that excludes
2037 coverage for (A) individuals eighteen years of age and younger, or (B)
2038 a period beyond twelve months following the insured's effective date
2039 of coverage. Any preexisting conditions provision shall only relate to
2040 conditions, whether physical or mental, for which medical advice,
2041 diagnosis or care or treatment was recommended or received during
2042 the twelve months immediately preceding the effective date of
2043 coverage] on any individual.

2044 (3) No insurance company, fraternal benefit society, hospital service
2045 corporation, medical service corporation or health care center shall
2046 refuse to issue an individual health insurance plan or insurance
2047 arrangement to [individuals eighteen years of age and younger] any
2048 individual solely on the basis that [an] such individual has a
2049 preexisting condition.

2050 [(c) All health insurance plans and insurance arrangements shall
2051 provide coverage, under the terms and conditions of their policies or
2052 contracts, for the preexisting conditions of any newly insured
2053 individual who was previously covered for such preexisting condition

2054 under the terms of the individual's preceding qualifying coverage,
2055 provided the preceding coverage was continuous to a date less than
2056 one hundred twenty days prior to the effective date of the new
2057 coverage, exclusive of any applicable waiting period, except in the case
2058 of a newly insured group member whose previous coverage was
2059 terminated due to an involuntary loss of employment, the preceding
2060 coverage must have been continuous to a date not more than one
2061 hundred fifty days prior to the effective date of the new coverage,
2062 exclusive of any applicable waiting period, provided such newly
2063 insured group member or dependent applies for such succeeding
2064 coverage within thirty days of the member's or dependent's initial
2065 eligibility.

2066 (d) With respect to a newly insured individual who was previously
2067 covered under qualifying coverage, but who was not covered under
2068 such qualifying coverage for a preexisting condition, as defined under
2069 the new health insurance plan or arrangement, such plan or
2070 arrangement shall credit the time such individual was previously
2071 covered by qualifying coverage to the exclusion period of the
2072 preexisting condition provision, provided the preceding coverage was
2073 continuous to a date less than one hundred twenty days prior to the
2074 effective date of the new coverage, exclusive of any applicable waiting
2075 period under such plan, except in the case of a newly insured group
2076 member whose preceding coverage was terminated due to an
2077 involuntary loss of employment, the preceding coverage must have
2078 been continuous to a date not more than one hundred fifty days prior
2079 to the effective date of the new coverage, exclusive of any applicable
2080 waiting period, provided such newly insured group member or
2081 dependent applies for such succeeding coverage within thirty days of
2082 the member's or dependent's initial eligibility.

2083 (e) Each insurance company, fraternal benefit society, hospital
2084 service corporation, medical service corporation or health care center
2085 which issues in this state group health insurance subject to Section
2086 2701 of the Public Health Service Act, as set forth in the Health

2087 Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
2088 (HIPAA), as amended from time to time, shall comply with the
2089 provisions of said section with respect to such group health insurance,
2090 except that the longer period of days specified in subsections (c) and
2091 (d) of this section shall apply to the extent excepted from preemption
2092 in Section 2723(B)(2)(iii) of said Public Health Service Act.

2093 (f) The provisions of this section shall apply to every health
2094 insurance plan or insurance arrangement issued, renewed or
2095 continued in this state on or after October 1, 1993. For purposes of this
2096 section, the date a plan or arrangement is continued shall be the
2097 anniversary date of the issuance of the plan or arrangement. The
2098 provisions of subsection (e) of this section shall apply on and after the
2099 dates specified in Sections 2747 and 2792 of the Public Health Service
2100 Act as set forth in HIPAA.]

2101 [(g)] (c) (1) Notwithstanding the provisions of subsection (a) of this
2102 section, a short-term health insurance policy issued on a nonrenewable
2103 basis for six months or less [which] that imposes a preexisting
2104 conditions provision shall be subject to the following conditions: [(1)]
2105 (A) No such preexisting conditions provision shall exclude coverage
2106 beyond twelve months following the insured's effective date of
2107 coverage; [(2)] (B) such preexisting conditions provision may only
2108 relate to conditions, whether physical or mental, for which medical
2109 advice, diagnosis, care or treatment was recommended or received
2110 during the twenty-four months immediately preceding the effective
2111 date of coverage; and [(3)] (C) any policy, application or sales brochure
2112 issued for such short-term health insurance policy that imposes such
2113 preexisting conditions provision shall disclose in a conspicuous
2114 manner in not less than fourteen-point bold face type the following
2115 statement:

2116 "THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR
2117 WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT
2118 WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-

2119 FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE
2120 DATE OF COVERAGE."

2121 (2) In the event an insurer or health care center issues two
2122 consecutive short-term health insurance policies on a nonrenewable
2123 basis for six months or less [which imposes] that impose a preexisting
2124 conditions provision to the same individual, the insurer or health care
2125 center shall reduce the preexisting conditions exclusion period in the
2126 second policy by the period of time such individual was covered under
2127 the first policy. If the same insurer or health care center issues a third
2128 or subsequent such short-term health insurance policy to the same
2129 individual, such insurer or health care center shall reduce the
2130 preexisting conditions exclusion period in the third or subsequent
2131 policy by the cumulative time covered under the prior policies.
2132 Nothing in this section shall be construed to require such short-term
2133 health insurance policy to be issued on a guaranteed issue or
2134 guaranteed renewable basis.

2135 [(h) The commissioner may adopt regulations, in accordance with
2136 the provisions of chapter 54, to enforce the provisions of HIPAA and
2137 this section concerning preexisting conditions and portability.]

2138 Sec. 29. Section 38a-513 of the general statutes is repealed and the
2139 following is substituted in lieu thereof (*Effective from passage*):

2140 (a) (1) No group health insurance policy, as defined by the
2141 commissioner, or certificate shall be issued or delivered in this state
2142 unless a copy of the form for such policy or certificate has been
2143 submitted to and approved by the commissioner under the regulations
2144 adopted pursuant to this section. The commissioner shall adopt
2145 regulations, in accordance with chapter 54, concerning the provisions,
2146 submission and approval of such policies and certificates and
2147 establishing a procedure for reviewing such policies and certificates. If
2148 the commissioner issues an order disapproving the use of such form,
2149 the provisions of section 38a-19 shall apply to such order.

2150 (2) No group health insurance policy or certificate for a small
2151 employer, as defined in section 38a-564, as amended by this act, shall
2152 be issued or delivered in this state unless the premium rates have been
2153 submitted to and approved by the commissioner. Premium rate filings
2154 shall include an actuarial memorandum that includes, but is not
2155 limited to, (A) pricing assumptions and claims experience, and (B)
2156 premium rates and loss ratios from the inception of the policy.

2157 (b) No insurance company, fraternal benefit society, hospital service
2158 corporation, medical service corporation, health care center or other
2159 entity [which] that delivers or issues for delivery in this state any
2160 Medicare supplement policies or certificates shall incorporate in its
2161 rates or determinations to grant coverage for Medicare supplement
2162 insurance policies or certificates any factors or values based on the age,
2163 gender, previous claims history or the medical condition of any person
2164 covered by such policy or certificate.

2165 (c) Nothing in this chapter shall preclude the issuance of a group
2166 health insurance policy [which] that includes an optional life insurance
2167 rider, provided the optional life insurance rider must be filed with and
2168 approved by the Insurance Commissioner pursuant to section 38a-430.
2169 Any company offering such policies for sale in this state shall be
2170 licensed to sell life insurance in this state pursuant to the provisions of
2171 section 38a-41.

2172 (d) Not later than January 1, 2009, the commissioner shall adopt
2173 regulations, in accordance with chapter 54, to establish minimum
2174 standards for benefits in group specified disease policies, certificates,
2175 riders, endorsements and benefits.

2176 Sec. 30. Sections 38a-553 to 38a-555, inclusive, 38a-565, 38a-568 and
2177 38a-570 to 38a-572, inclusive, of the general statutes are repealed.
2178 (*Effective from passage*)

2179 Sec. 31. Section 38a-538 of the 2014 supplement to the general
2180 statutes is repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	38a-551
Sec. 2	<i>from passage</i>	38a-552
Sec. 3	<i>from passage</i>	38a-556
Sec. 4	<i>from passage</i>	38a-557
Sec. 5	<i>from passage</i>	38a-564
Sec. 6	<i>from passage</i>	38a-566
Sec. 7	<i>from passage</i>	38a-567
Sec. 8	January 1, 2015	38a-567(2)(B)
Sec. 9	<i>from passage</i>	38a-569
Sec. 10	<i>from passage</i>	38a-574
Sec. 11	<i>from passage</i>	38a-537
Sec. 12	<i>from passage</i>	38a-512a
Sec. 13	<i>from passage</i>	5-248a(f)
Sec. 14	<i>from passage</i>	5-259(i)
Sec. 15	January 1, 2015	5-259(i)
Sec. 16	<i>from passage</i>	12-201(7)
Sec. 17	<i>from passage</i>	12-211(c)
Sec. 18	<i>from passage</i>	12-212a
Sec. 19	<i>from passage</i>	17b-265(e)
Sec. 20	<i>from passage</i>	17b-284(c)
Sec. 21	<i>from passage</i>	17b-299(c)(6)
Sec. 22	<i>from passage</i>	17b-611(b)
Sec. 23	<i>from passage</i>	19a-7b(b)
Sec. 24	<i>from passage</i>	31-51o(a)
Sec. 25	<i>from passage</i>	38a-472d
Sec. 26	<i>from passage</i>	38a-505
Sec. 27	<i>from passage</i>	38a-573
Sec. 28	<i>from passage</i>	38a-476
Sec. 29	<i>from passage</i>	38a-513
Sec. 30	<i>from passage</i>	Repealer section
Sec. 31	<i>from passage</i>	Repealer section

Statement of Purpose:

To make changes to the duties of the Health Reinsurance Association and requirements of the Connecticut Small Employer Reinsurance Pool, to update the preexisting conditions statute, and to require

approval of small employer premium rates by the Insurance Department.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]