



Senate

General Assembly

File No. 364

February Session, 2014

Substitute Senate Bill No. 478

Senate, April 7, 2014

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

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 CERTAIN GROUP HEALTH INSURANCE POLICIES.

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 Section 38a-551 of the general statutes is repealed and the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)] (7) "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 this section and sections [38a-
287 505, 38a-546 and] 38a-551, as amended by this act, and 38a-556a to 38a-
288 559, inclusive; (2) sue or be sued, including taking any legal actions
289 necessary or proper for recovery of any assessments for, on behalf of,
290 or against participating members; (3) take such legal action as
291 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 this section and
301 sections [38a-505, 38a-546 and] 38a-551, as amended by this act, and
302 38a-556a to 38a-559, inclusive, 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 this section
392 and sections [38a-505, 38a-546 and] 38a-551, as amended by this act,
393 and 38a-556a to 38a-559, inclusive, 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 this section and sections [38a-505, 38a-546 and] 38a-
420 551, as amended by this act, and 38a-556a to 38a-559, inclusive. This
421 provision shall not apply to the obligations of a carrier, a self-insurer,
422 the Health Reinsurance Association or the residual market mechanism
423 for payment of benefits provided under a [comprehensive] health care
424 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] includes any employee who is not

473 actively at work but is covered under the small employer's health
474 insurance plan pursuant to (A) workers' compensation, (B)
475 continuation of benefits pursuant to section [38a-554] 38a-512a, as
476 amended by this act, or (C) other applicable laws.

477 (4) (A) "Small employer" means any person, firm, corporation,
478 limited liability company, partnership or association actively engaged
479 in business or self-employed for at least three consecutive months
480 who, on at least fifty per cent of its working days during the preceding
481 twelve months, employed no more than fifty eligible employees, the
482 majority of whom were employed within the state of Connecticut.
483 "Small employer" includes a self-employed individual. For the
484 purposes of determining the number of eligible employees under this
485 subdivision: (i) Companies that are affiliated companies, as defined in
486 section 33-840, or that are eligible to file a combined tax return for
487 purposes of taxation under chapter 208 shall be considered one
488 employer; (ii) employees covered through the employer by health
489 insurance plans or insurance arrangements issued to or in accordance
490 with a trust established pursuant to collective bargaining subject to the
491 federal Labor Management Relations Act shall not be counted; (iii)
492 employees who are not actively at work but are covered under the
493 small employer's health insurance plan pursuant to workers'
494 compensation, continuation of benefits pursuant to section [38a-554]
495 38a-512a, as amended by this act, or other applicable laws shall not be
496 counted; and (iv) employees who work a normal work week of less
497 than thirty hours shall not be counted. Except as otherwise specifically
498 provided, provisions of this section and sections 12-201, as amended
499 by this act, 12-211, as amended by this act, 12-212a, as amended by this
500 act, [and 38a-565 to 38a-572] 38a-566, as amended by this act, 38a-567,
501 as amended by this act, and 38a-569, as amended by this act, inclusive,
502 that apply to a small employer shall continue to apply until the plan
503 anniversary following the date the employer no longer meets the
504 requirements of this definition.

505 (B) "Small employer" does not include (i) a municipality procuring
506 health insurance pursuant to section 5-259, as amended by this act, (ii)

507 a private school in this state procuring health insurance through a
508 health insurance plan or an insurance arrangement sponsored by an
509 association of such private schools, (iii) a nonprofit organization
510 procuring health insurance pursuant to section 5-259, as amended by
511 this act, unless the Secretary of the Office of Policy and Management
512 and the State Comptroller make a request in writing to the Insurance
513 Commissioner that such nonprofit organization be deemed a small
514 employer for the purposes of this chapter, (iv) an association for
515 personal care assistants procuring health insurance pursuant to section
516 5-259, as amended by this act, or (v) a community action agency
517 procuring health insurance pursuant to section 5-259, as amended by
518 this act.

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

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

527 (7) "Health insurance plan" means any hospital and medical expense
528 incurred policy, hospital or medical service plan contract and health
529 care center subscriber contract. [and] "Health insurance plan" does not
530 include (A) accident only, credit, dental, vision, Medicare supplement,
531 long-term care or disability insurance, hospital indemnity coverage,
532 coverage issued as a supplement to liability insurance, insurance
533 arising out of a workers' compensation or similar law, automobile
534 medical-payments insurance, or insurance under which beneficiaries
535 are payable without regard to fault and which is statutorily required to
536 be contained in any liability insurance policy or equivalent self-
537 insurance, or (B) policies of specified disease or limited benefit health
538 insurance, provided that the carrier offering such policies files on or
539 before March first of each year a certification with the commissioner

540 that contains the following: (i) A statement from the carrier certifying
541 that such policies are being offered and marketed as supplemental
542 health insurance and not as a substitute for hospital or medical
543 expense insurance; (ii) a summary description of each such policy
544 including the average annual premium rates, or range of premium
545 rates in cases where premiums vary by age, gender or other factors,
546 charged for such policies in the state; and (iii) in the case of a policy
547 that is described in this subparagraph and that is offered for the first
548 time in this state on or after October 1, 1993, the carrier files with the
549 commissioner the information and statement required in this
550 subparagraph at least thirty days prior to the date such policy is issued
551 or delivered in this state.

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

555 [(9) "Late enrollee" means an eligible employee or dependent who
556 requests enrollment in a small employer's health insurance plan
557 following the initial enrollment period provided under the terms of the
558 first plan for which such employee or dependent was eligible through
559 such small employer, provided an eligible employee or dependent
560 shall not be considered a late enrollee if (A) the request for enrollment
561 is made within thirty days after termination of coverage provided
562 under another group health insurance plan and if the individual had
563 not initially requested coverage under such plan solely because he was
564 covered under another group health insurance plan and coverage
565 under that plan has ceased due to termination of employment, death of
566 a spouse, or divorce, or due to that plan's involuntary termination or
567 cancellation by its carrier for reasons other than nonpayment of
568 premium, or (B) the individual is employed by an employer who offers
569 multiple health insurance plans and the individual elects a different
570 health insurance plan during an open enrollment period, or (C) a court
571 has ordered coverage be provided for a spouse or minor child under a
572 covered employee's plan and request for enrollment is made within
573 thirty days after issuance of such court order, or (D) if the request for

574 enrollment is made within thirty days after the marriage of such
575 employee or the birth or adoption of the first child by such employee
576 after the later of the commencement of the employer's plan or the date
577 the pool becomes operational, and satisfactory evidence of such
578 marriage, birth or adoption is provided to the small employer carrier.

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

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

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

587 [(13)] (9) "Dependent" means the spouse or child of an eligible
588 employee, subject to applicable terms of the health insurance plan
589 covering such employee. "Dependent" [shall also include] includes any
590 dependent that is covered under the small employer's health insurance
591 plan pursuant to workers' compensation, continuation of benefits
592 pursuant to section [38a-554] 38a-512a, as amended by this act, or other
593 applicable laws.

594 [(14)] (10) "Commissioner" means the Insurance Commissioner.

595 [(15)] (11) "Member" means each insurer and insurance arrangement
596 participating in the pool.

597 [(16)] (12) "Small employer carrier" means any insurer or insurance
598 arrangement [which] that offers or maintains group health insurance
599 plans covering eligible employees of one or more small employers.

600 [(17) "Preexisting conditions provision" means a policy provision
601 that excludes coverage for charges or expenses incurred during a
602 specified period following the insured's effective date of coverage as to
603 a condition that, during a specified period immediately preceding the

604 effective date of coverage, had manifested itself in such a manner as
605 would cause an ordinary prudent person to seek diagnosis, care or
606 treatment or for which medical advice, diagnosis, care or treatment
607 was recommended or received as to that condition.

608 (18) "Base premium rate" means, as to any health insurance plan or
609 insurance arrangement covering one or more employees of a small
610 employer, the lowest new business premium rate charged by the
611 insurer or insurance arrangement for the same or similar coverage
612 which is equivalent in value under a plan or arrangement covering any
613 small employer with similar case characteristics, other than claim
614 experience, as determined by such insurer or insurance arrangement,
615 except that as to any small employer carrier or insurance arrangement
616 not issuing new health insurance plans or insurance arrangements to a
617 small employer, "base premium rate" means the lowest rate charged a
618 small employer for the same or similar coverage which is equivalent in
619 value, under a plan or arrangement covering any small employer with
620 similar case characteristics, other than claim experience, as determined
621 by such insurer or insurance arrangement.

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

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

632 (21) "Health Reinsurance Association" means the entity established
633 and maintained in accordance with the provisions of sections 38a-505,
634 38a-546 and 38a-551 to 38a-559, inclusive.

635 (22) "Reimbursement rate" means, as to individuals covered under

636 special health care plans or an individual special health care plan,
637 seventy-five per cent of the Medicare reimbursement rate for benefits
638 normally reimbursable under Medicare. For services or supplies not
639 reimbursed by Medicare, such reimbursement shall be seventy-five per
640 cent of the amount which would be payable under Medicare, if
641 Medicare was responsible for benefit payments under such plans for
642 such services and supplies, as determined by the board and approved
643 by the commissioner.

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

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

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

657 [(26)] (13) "Health care center" [means health care center as defined]
658 has the same meaning as provided in section 38a-175.

659 [(27)] (14) "Case characteristics" means demographic or other
660 objective characteristics of a small employer, including age [, sex,
661 family composition, location, size of group, administrative cost savings
662 resulting from the administration of an association group plan or a
663 plan written pursuant to section 5-259 and industry classification, as
664 determined by a small employer carrier, that are considered by the
665 small employer carrier in the determination of premium rates for the
666 small employer. Claim] and geographic location. "Case characteristics"
667 does not include claims experience, health status [, and] or duration of

668 coverage since issue. [are not case characteristics for the purpose of
669 sections 38a-564 to 38a-572, inclusive.]

670 [(28) "Actuarial certification" means a written statement by a
671 member of the American Academy of Actuaries or other individual
672 acceptable to the commissioner that a small employer carrier is in
673 compliance with the provisions of subdivisions (4), (6), (7) and (9) of
674 section 38a-567 and the regulations promulgated by the commissioner
675 pursuant to section 38a-567, based upon the person's examination,
676 including a review of the appropriate records and of the actuarial
677 assumptions and methods used by the small employer carrier in
678 establishing premium rates for applicable health benefit plans.]

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

681 (a) Any individual or group health insurance plan or any insurance
682 arrangement shall be subject to the provisions of sections [12-201, 12-
683 211, 12-212a and] 38a-552, as amended by this act, 38a-564, as amended
684 by this act, [to 38a-572, inclusive] 38a-567, as amended by this act, and
685 38a-569, as amended by this act, if it provides health insurance or is an
686 insurance arrangement covering one or more employees of a small
687 employer and if any one of the following conditions are met:

688 (1) Any portion of the premium or benefits is paid by a small
689 employer or any covered individual is reimbursed, whether through
690 wage adjustments or otherwise, by a small employer for any portion of
691 the premium; or

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

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

699 (c) Notwithstanding the provisions of subsection (a) of this section,
700 health insurance plans or insurance arrangements issued to or in
701 accordance with a trust established pursuant to collective bargaining,
702 subject to the federal Labor Management Relations Act and which
703 cover, in the aggregate, more than twenty-five employees of all
704 participating employers, shall not be subject to the provisions of
705 section 38a-567, as amended by this act, or subparagraph (A) of
706 subdivision (2) of subsection [(e)] (c) of section 38a-569, as amended by
707 this act. [and insurers or insurance arrangements issuing only such
708 plans shall not be considered small employer carriers for purposes of
709 sections 38a-565 and 38a-568.]

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

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

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

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

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

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

732 Health insurance plans, associations of small employers and other
733 insurance arrangements covering small employers and insurers and
734 producers marketing such plans and arrangements shall be subject to
735 the following provisions:

736 [(1) (A) (i) Any such insurer or producer marketing such plans or
737 arrangements shall offer premium quotes to small employers upon
738 request for coverage for employees who work a normal work week of
739 thirty or more hours. Upon request by a small employer, such insurer
740 or producer shall offer premium quotes for coverage for employees
741 that include those who work a normal work week of at least twenty
742 hours.

743 (ii) No small employer that has requested premium quotes for
744 coverage for employees that include those who work a normal work
745 week of less than thirty hours shall be required to accept such quotes
746 or coverage in lieu of premium quotes or coverage for only those
747 employees who work a normal work week of thirty or more hours.

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

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

756 (B) Any such plan or arrangement shall be renewable with respect
757 to all eligible employees or dependents at the option of the small
758 employer, policyholder or contractholder, as the case may be, except:
759 (i) For nonpayment of the required premiums by the small employer,
760 policyholder or contractholder; (ii) for fraud or misrepresentation of

761 the small employer, policyholder or contractholder or, with respect to
762 coverage of individual insured, the insureds or their representatives;
763 (iii) for noncompliance with plan or arrangement provisions; (iv) when
764 the number of insureds covered under the plan or arrangement is less
765 than the number of insureds or percentage of insureds required by
766 participation requirements under the plan or arrangement; or (v) when
767 the small employer, policyholder or contractholder is no longer
768 actively engaged in the business in which it was engaged on the
769 effective date of the plan or arrangement.

770 (C) Renewability of coverage may be effected by either continuing
771 in effect a plan or arrangement covering a small employer or by
772 substituting upon renewal for the prior plan or arrangement the plan
773 or arrangement then offered by the carrier that most closely
774 corresponds to the prior plan or arrangement and is available to other
775 small employers. Such substitution shall only be made under
776 conditions approved by the commissioner. A carrier may substitute a
777 plan or arrangement as [stated above] set forth in this subparagraph
778 only if the carrier effects the same substitution upon renewal for all
779 small employers previously covered under the particular plan or
780 arrangement, unless otherwise approved by the commissioner. The
781 substitute plan or arrangement shall be subject to the rating restrictions
782 specified in this section on the same basis as if no substitution had
783 occurred, except for an adjustment based on coverage differences.

784 [(D) Notwithstanding the provisions of this subdivision, any such
785 plan or arrangement, or any coverage provided under such plan or
786 arrangement may be rescinded for fraud, intentional material
787 misrepresentation or concealment by an applicant, employee,
788 dependent or small employer.

789 (E) Any individual who was not a late enrollee at the time of his or
790 her enrollment and whose coverage is subsequently rescinded shall be
791 allowed to reenroll as of a current date in such plan or arrangement
792 subject to any preexisting condition or other provisions applicable to
793 new enrollees without previous coverage. On and after the effective

794 date of such individual's reenrollment, the small employer carrier may
795 modify the premium rates charged to the small employer for the
796 balance of the current rating period and for future rating periods, to
797 the level determined by the carrier as applicable under the carrier's
798 established rating practices had full, accurate and timely underwriting
799 information been supplied when such individual initially enrolled in
800 the plan. The increase in premium rates allowed by this provision for
801 the balance of the current rating period shall not exceed twenty-five
802 per cent of the small employer's current premium rates. Any such
803 increase for the balance of said current rating period shall not be
804 subject to the rate limitation specified in subdivision (6) of this section.
805 The rate limitation specified in this section shall otherwise be fully
806 applicable for the current and future rating periods. The modification
807 of premium rates allowed by this subdivision shall cease to be
808 permitted for all plans and arrangements on the first rating period
809 commencing on or after July 1, 1995.

810 (2) Except in the case of a late enrollee who has failed to provide
811 evidence of insurability satisfactory to the insurer, the plan or
812 arrangement may not exclude any eligible employee or dependent
813 who would otherwise be covered under such plan or arrangement on
814 the basis of an actual or expected health condition of such person. No
815 plan or arrangement may exclude an eligible employee or eligible
816 dependent who, on the day prior to the initial effective date of the plan
817 or arrangement, was covered under the small employer's prior health
818 insurance plan or arrangement pursuant to workers' compensation,
819 continuation of benefits pursuant to section 38a-554 or other applicable
820 laws. The employee or dependent must request coverage under the
821 new plan or arrangement on a timely basis and such coverage shall
822 terminate in accordance with the provisions of the applicable law.

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

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

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

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

841 (B) An adjustment of the small employer's premium rates for the
842 prior rating period, and adjusted pro rata for rating periods of less
843 than one year, due to the claim experience, health status or duration of
844 coverage of the employees or dependents of the small employer, such
845 adjustment (i) not to exceed ten per cent annually for the rating
846 periods commencing on or after October 1, 1993, and prior to July 1,
847 1994, and (ii) not to exceed five per cent annually for the rating periods
848 commencing on or after July 1, 1994, and prior to July 1, 1995; and

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

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

858 [(5) (A)] (2) (A) With respect to grandfathered plans [or

859 arrangements issued on or after July 1, 1995] issued to small
860 employers, the premium rates charged or offered [to small employers]
861 shall be established on the basis of a [community rate] single pool of all
862 grandfathered plans, adjusted to reflect one or more of the following
863 classifications:

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

866 (ii) Gender;

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

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

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

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

886 (vii) Savings resulting from a reduction in the profit of a carrier
887 [who] that writes small business plans or arrangements for an
888 association group plan or a plan written pursuant to section 5-259, as
889 amended by this act, provided any loss in overall revenue due to a

890 reduction in profit is not shifted to other small employers; and

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

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

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

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

920 (7) For rating periods commencing prior to July 1, 1995, in any case
921 where a small employer carrier utilized industry classification as a case

922 characteristic in establishing premium rates, the rate factor associated
923 with any industry classification shall not vary from the arithmetical
924 average of the highest and lowest rate factors associated with all
925 industry classifications by greater than fifteen per cent of such average.

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

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

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

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

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

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

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

960 (iii) Premium rates for employees and dependents for
961 nongrandfathered plans shall be calculated for each covered individual
962 and premium rates for the small employer group shall be calculated by
963 totaling the premiums attributable to each covered individual.

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

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

970 [(11)] (3) No small employer carrier or producer shall, directly or
971 indirectly, engage in the following activities:

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

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

983 [(12)] (4) No small employer carrier shall, directly or indirectly,
984 enter into any contract, agreement or arrangement with a producer
985 that provides for or results in the compensation paid to a producer for
986 the sale of a health benefit plan to be varied because of the health
987 status, claims experience, industry, occupation or geographic area of
988 the small employer. A small employer carrier shall provide reasonable
989 compensation, as provided under the plan of operation of the
990 program, to a producer, if any, for the sale of a [special or a small
991 employer] health care plan. No small employer carrier shall terminate,
992 fail to renew or limit its contract or agreement of representation with a
993 producer for any reason related to the health status, claims experience,
994 occupation, or geographic location of the small employers placed by
995 the producer with the small employer carrier.

996 [(13)] (5) No small employer carrier or producer shall induce or
997 otherwise encourage a small employer to separate or otherwise
998 exclude an employee from health coverage or benefits provided in
999 connection with the employee's employment.

1000 [(14)] Denial by a small employer carrier of an application for
1001 coverage from a small employer shall be in writing and shall state the
1002 reasons for the denial.]

1003 [(15)] (6) No small employer carrier or producer shall disclose (A) to
1004 a small employer the fact that any or all of the eligible employees of
1005 such small employer have been or will be reinsured with the pool, or
1006 (B) to any eligible employee or dependent the fact that he has been or
1007 will be reinsured with the pool.

1008 [(16)] (7) If a small employer carrier enters into a contract,
1009 agreement or other arrangement with another party to provide
1010 administrative, marketing or other services related to the offering of
1011 health benefit plans to small employers in this state, the other party
1012 shall be subject to the provisions of this section.

1013 [(17)] (8) The commissioner may adopt regulations in accordance
1014 with the provisions of chapter 54 setting forth additional standards to

1015 provide for the fair marketing and broad availability of health benefit
1016 plans to small employers.

1017 [(18) Each small employer carrier shall maintain at its principal
1018 place of business a complete and detailed description of its rating
1019 practices and renewal underwriting practices, including information
1020 and documentation that demonstrates that its rating methods and
1021 practices are based upon commonly accepted actuarial assumptions
1022 and are in accordance with sound actuarial principles. Each small
1023 employer carrier shall file with the commissioner annually, on or
1024 before March fifteenth, an actuarial certification certifying that the
1025 carrier is in compliance with this part and that the rating methods have
1026 been derived using recognized actuarial principles consistent with the
1027 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
1028 shall be in a form and manner and shall contain such information as
1029 determined by the commissioner. A copy of the certification shall be
1030 retained by the small employer carrier at its principal place of
1031 business. Any information and documentation described in this
1032 subdivision but not subject to the filing requirement shall be made
1033 available to the commissioner upon his request. Except in cases of
1034 violations of sections 38a-564 to 38a-573, inclusive, the information
1035 shall be considered proprietary and trade secret information and shall
1036 not be subject to disclosure by the commissioner to persons outside of
1037 the department except as agreed to by the small employer carrier or as
1038 ordered by a court of competent jurisdiction.

1039 (19) The commissioner may suspend all or any part of this section
1040 relating to the premium rates applicable to one or more small
1041 employers for one or more rating periods upon a filing by the small
1042 employer carrier and a finding by the commissioner that either the
1043 suspension is reasonable in light of the financial condition of the
1044 carrier or that the suspension would enhance the efficiency and
1045 fairness of the marketplace for small employer health insurance.

1046 (20) For rating periods commencing prior to July 1, 1995, a small
1047 employer carrier shall quote premium rates to any small employer

1048 within thirty days after receipt by the carrier of such employer's
1049 completed application.]

1050 ~~[(21)]~~ (9) Any violation of subdivisions ~~[(10) to (16)]~~ (3) to (7),
1051 inclusive, of this section and of any regulations established under
1052 subdivision ~~[(17)]~~ (8) of this section shall be an unfair and prohibited
1053 practice under sections 38a-815 to 38a-830, inclusive.

1054 ~~[(22) (A)]~~ (A) With respect to plans or arrangements issued pursuant to
1055 subsection (i) of section 5-259, at the option of the Comptroller, the
1056 premium rates charged or offered to small employers purchasing
1057 health insurance shall not be subject to this section, provided (i) the
1058 plan or plans offered or issued cover such small employers as a single
1059 entity and cover not less than three thousand employees on the date
1060 issued, (ii) each small employer is charged or offered the same
1061 premium rate with respect to each employee and dependent, and (iii)
1062 the plan or plans are written on a guaranteed issue basis.

1063 (B) With respect to plans or arrangements issued by an association
1064 group plan, at the option of the administrator of the association group
1065 plan, the premium rates charged or offered to small employers
1066 purchasing health insurance shall not be subject to this section,
1067 provided (i) the plan or plans offered or issued cover such small
1068 employers as a single entity and cover not less than three thousand
1069 employees on the date issued, (ii) each small employer is charged or
1070 offered the same premium rate with respect to each employee and
1071 dependent, and (iii) the plan or plans are written on a guaranteed issue
1072 basis. In addition, such association group (I) shall be a bona fide group
1073 as set forth in the Employee Retirement and Security Act of 1974, (II)
1074 shall not be formed for the purposes of fictitious grouping, as defined
1075 in section 38a-827, and (III) shall not issue any plan that shall cause
1076 undue disruption in the insurance marketplace, as determined by the
1077 commissioner.]

1078 Sec. 8. Subparagraph (B) of subdivision (2) of section 38a-567 of the
1079 general statutes, as amended by section 7 of this act, is repealed and
1080 the following is substituted in lieu thereof (*Effective January 1, 2015*):

1081 (B) (i) With respect to nongrandfathered plans issued to small
1082 employers, the premium rates charged or offered shall be established
1083 on the basis of a single pool of all nongrandfathered plans, adjusted to
1084 reflect one or more of the following classifications:

1085 (I) Age, in accordance with a uniform age rating curve established
1086 by the commissioner;

1087 (II) Geographic area, as defined by the commissioner; [.]

1088 (III) Tobacco use, except that such rate may not vary by a ratio of
1089 greater than 1.5 to 1.0 and may only be applied with respect to
1090 individuals who may legally use tobacco under state and federal law.
1091 For purposes of this subparagraph, "tobacco use" means the use of
1092 tobacco products four or more times per week on average within a
1093 period not longer than the six months immediately preceding.
1094 "Tobacco use" does not include the religious or ceremonial use of
1095 tobacco.

1096 (ii) Total premium rates for family coverage for nongrandfathered
1097 plans shall be determined by adding the premiums for each individual
1098 family member, except that with respect to family members under
1099 twenty-one years of age, the premiums for only the three oldest
1100 covered children shall be taken into account in determining the total
1101 premium rate for such family.

1102 (iii) Premium rates for employees and dependents for
1103 nongrandfathered plans shall be calculated for each covered individual
1104 and premium rates for the small employer group shall be calculated by
1105 totaling the premiums attributable to each covered individual.

1106 (iv) Premium rates for any given nongrandfathered plan may vary
1107 by actuarially justified amounts to reflect the plan's provider network
1108 and administrative expense differences that can be reasonably
1109 allocated to such plan.

1110 Sec. 9. Section 38a-569 of the general statutes is repealed and the
1111 following is substituted in lieu thereof (*Effective from passage*):

1112 (a) (1) There is established a nonprofit entity to be known as the
1113 "Connecticut Small Employer Health Reinsurance Pool". All insurers
1114 issuing health insurance in this state and insurance arrangements
1115 providing health plan benefits in this state on and after July 1, 1990,
1116 shall be members of the pool.

1117 (2) On or before July 15, 1990, the commissioner shall give notice to
1118 all insurers and insurance arrangements of the time and place for the
1119 initial organizational meeting, which shall take place by September 1,
1120 1990. The members shall select the initial board, subject to approval by
1121 the commissioner. The board shall consist of at least five and not more
1122 than nine representatives of members. There shall be no more than two
1123 members of the board representing any one insurer or insurance
1124 arrangement. In determining voting rights at the organizational
1125 meeting, each member shall be entitled to vote in person or by proxy.
1126 The vote shall be weighted based upon net health insurance premium
1127 derived from this state in the previous calendar year. To the extent
1128 possible, at least one-third of the members of the board shall be
1129 domestic insurance companies and at least two-thirds of the members
1130 of the board shall be small employer carriers. At least one member of
1131 the board shall be a health care center and at least one member shall be
1132 a small employer carrier with less than one hundred million dollars in
1133 net small employer health insurance premium in this state. The
1134 Insurance Commissioner shall be an ex-officio member of the board.
1135 The net premium amount shall be adjusted by the board periodically
1136 for health care cost inflation. In approving selection of the board, the
1137 commissioner shall assure that all members are fairly represented. The
1138 membership of all boards subsequent to the initial board shall, to the
1139 extent possible, reflect the same distribution of representation as is
1140 described in this subdivision.

1141 (3) If the initial board is not elected at the organizational meeting,
1142 the commissioner shall appoint the initial board within fifteen days of
1143 the organizational meeting.

1144 (4) Within ninety days after the appointment of such initial board,

1145 the board shall submit to the commissioner a plan of operation and
1146 thereafter any amendments thereto necessary or suitable to assure the
1147 fair, reasonable and equitable administration of the pool. The
1148 commissioner shall, after notice and hearing, approve the plan of
1149 operation provided he determines it to be suitable to assure the fair,
1150 reasonable and equitable administration of the pool, and provides for
1151 the sharing of pool gains or losses on an equitable proportionate basis
1152 in accordance with the provisions of subsection (d) of this section,
1153 revision of 1958, revised to January 1, 2013. The plan of operation shall
1154 become effective upon approval in writing by the commissioner
1155 consistent with the date on which the coverage under this section shall
1156 be made available. If the board fails to submit a suitable plan of
1157 operation within one hundred eighty days after its appointment, or at
1158 any time thereafter fails to submit suitable amendments to the plan of
1159 operation, the commissioner shall, after notice and hearing, adopt and
1160 promulgate a plan of operation or amendments, as appropriate. The
1161 commissioner shall amend any plan adopted by him, as necessary, at
1162 the time a plan of operation is submitted by the board and approved
1163 by the commissioner.

1164 (5) ~~[The]~~ On and after the effective date of this section, the plan of
1165 operation shall establish procedures for: (A) Handling and accounting
1166 of assets and moneys of the pool, and for an annual fiscal reporting to
1167 the commissioner; (B) filling vacancies on the board, subject to the
1168 approval of the commissioner; (C) selecting an administrator and
1169 setting forth the powers and duties of the administrator; (D) reinsuring
1170 risks; ~~[in accordance with the provisions of this section;]~~ (E) collecting
1171 assessments from all members to provide for claims reinsured by the
1172 pool and for administrative expenses incurred or estimated to be
1173 incurred during the period for which the assessment is made; and (F)
1174 any additional matters at the discretion of the board.

1175 (6) The pool shall have the general powers and authority granted
1176 under the laws of Connecticut to insurance companies licensed to
1177 transact health insurance and, in addition thereto, the specific
1178 authority to: (A) Enter into contracts as are necessary or proper to

1179 carry out the provisions and purposes of this section, including the
1180 authority, with the approval of the commissioner, to enter into
1181 contracts with programs of other states for the joint performance of
1182 common functions, or with persons or other organizations for the
1183 performance of administrative functions; (B) sue or be sued, including
1184 taking any legal actions necessary or proper for recovery of any
1185 assessments for, on behalf of, or against members; (C) take such legal
1186 action as necessary to avoid the payment of improper claims against
1187 the pool; (D) define the array of health coverage products for which
1188 reinsurance will be provided, and to issue reinsurance policies, in
1189 accordance with the requirements of this section; (E) establish rules,
1190 conditions and procedures pertaining to the reinsurance of members'
1191 risks by the pool; (F) establish appropriate rates, rate schedules, rate
1192 adjustments, rate classifications and any other actuarial functions
1193 appropriate to the operation of the pool; (G) assess members in
1194 accordance with the provisions of subsection (e) of this section, and to
1195 make advance interim assessments as may be reasonable and
1196 necessary for organizational and interim operating expenses. Any such
1197 interim assessments shall be credited as offsets against any regular
1198 assessments due following the close of the fiscal year; (H) appoint from
1199 among members appropriate legal, actuarial and other committees as
1200 necessary to provide technical assistance in the operation of the pool,
1201 policy and other contract design, and any other function within the
1202 authority of the pool; and (I) borrow money to effect the purposes of
1203 the pool. Any notes or other evidence of indebtedness of the pool not
1204 in default shall be legal investments for insurers and may be carried as
1205 admitted assets.

1206 (b) Any member whose health insurance plan is subject to section
1207 38a-567, as amended by this act, may reinsure with the pool coverage
1208 of an eligible employee of a small employer [,] or any dependent of
1209 such an employee. [, except that no member may reinsure with the
1210 pool coverage of an eligible employee of a small employer, or any
1211 dependent of such an employee, whose premium rates are not subject
1212 to section 38a-567 pursuant to subdivision (22) of section 38a-567. Any
1213 reinsurance placed with the pool from the date of the establishment of

1214 the pool regarding the coverage of an eligible employee of a small
1215 employer, or any dependent of such an employee shall be provided as
1216 follows:]

1217 [(1) (A) With respect to a special health care plan or a small
1218 employer health care plan, the pool shall reinsure the level of coverage
1219 provided; (B) with respect to other plans, the pool shall reinsure the
1220 level of coverage provided up to, but not exceeding, the level of
1221 coverage provided in a small employer health care plan or the
1222 actuarial equivalent thereof as defined and authorized by the board;
1223 and (C) in either case, no reinsurance may be provided in any calendar
1224 year for a reinsured employee or dependent until five thousand dollars
1225 in benefit payments have been made for services provided during that
1226 calendar year for that reinsured employee or dependent, which
1227 payments would have been reimbursed through said reinsurance in
1228 the absence of the annual five-thousand-dollar deductible. The amount
1229 of the deductible shall be periodically reviewed by the board and may
1230 be adjusted for appropriate factors as determined by the board;

1231 (2) With respect to eligible employees, and their dependents,
1232 coverage may be reinsured: (A) Within such period of time after the
1233 commencement of their coverage under the plan as may be authorized
1234 by the board, or (B) commencing January 1, 1992, on the first plan
1235 anniversary after the employer's coverage has been in effect with the
1236 small employer carrier for a period of three years, and every third plan
1237 anniversary thereafter, provided, commencing May 1, 1994,
1238 reinsurance pursuant to this subparagraph shall only be permitted
1239 with respect to eligible employees and their dependents of a small
1240 employer which has no more than two eligible employees as of the
1241 applicable anniversary;

1242 (3) Reinsurance coverage may be terminated for each reinsured
1243 employee or dependent on any plan anniversary;

1244 (4) Reinsurance of newborn dependents shall be allowed only if the
1245 mother of any such dependent is reinsured as of the date of birth of
1246 such child, and all newborn dependents of reinsured persons shall be

1247 automatically reinsured as of their date of birth; and

1248 (5) Notwithstanding the provisions of subparagraph (A) of
1249 subdivision (2) of this subsection: (A) Coverage for eligible employees
1250 and their dependents provided under a group policy covering two or
1251 more small employers shall not be eligible for reinsurance when such
1252 coverage is discontinued and replaced by a group policy of another
1253 carrier covering two or more small employers, unless coverage for
1254 such eligible employees or dependents was reinsured by the prior
1255 carrier; and (B) at the time coverage is assumed for such group by a
1256 succeeding carrier, such carrier shall notify the pool of its intention to
1257 provide coverage for such group and shall identify the employees and
1258 dependents whose coverage will continue to be reinsured. The time
1259 limitations for providing such notice shall be established by the pool.

1260 (c) Except as provided in subsection (d) of this section, premium
1261 rates charged for reinsurance by the pool shall be established at the
1262 following percentages of the rate established by the pool for that
1263 classification or group with similar characteristics and coverage:

1264 (1) One hundred fifty per cent, with respect to all of the eligible
1265 employees, and their dependents, of a small employer, all of whose
1266 coverage is reinsured in accordance with subdivision (2) of subsection
1267 (b) of this section; and

1268 (2) Five hundred per cent, with respect to an eligible employee or
1269 dependent who is individually reinsured in accordance with
1270 subdivision (2) of subsection (b) of this section and is not reinsured
1271 with all eligible employees of an employer and their dependents.

1272 (d) Premium rates charged for reinsurance by the pool to a health
1273 care center which is approved by the Secretary of Health and Human
1274 Services as a health maintenance organization pursuant to 42 USC 300
1275 et seq., and as such is subject to requirements that limit the amount of
1276 risk that may be ceded to the pool, may be modified by the board, if
1277 appropriate, to reflect the portion of risk that may be ceded to the
1278 pool.]

1279 [(e)] (c) (1) Following the close of each fiscal year, the administrator
1280 shall determine the net premiums, the pool expenses of administration
1281 and the incurred losses for the year, taking into account investment
1282 income and other appropriate gains and losses. For purposes of this
1283 section, health insurance premiums earned by insurance arrangements
1284 shall be established by adding paid health losses and administrative
1285 expenses of the insurance arrangement. Health insurance premiums
1286 and benefits paid by a member that are less than an amount
1287 determined by the board to justify the cost of collection shall not be
1288 considered for purposes of determining assessments. For purposes of
1289 this subsection, "net premiums" means health insurance premiums,
1290 less administrative expense allowances.

1291 (2) Any net loss for the year shall be recouped by assessments of
1292 members.

1293 (A) Assessments shall first be apportioned by the board among all
1294 members in proportion to their respective shares of the total health
1295 insurance premiums earned in this state from health insurance plans
1296 and insurance arrangements covering small employers during the
1297 calendar year coinciding with or ending during the fiscal year of the
1298 pool, or on any other equitable basis reflecting coverage of small
1299 employers as may be provided in the plan of operations. An
1300 assessment shall be made pursuant to this subparagraph against a
1301 health care center, [which] that is approved by the Secretary of Health
1302 and Human Services as a health maintenance organization pursuant to
1303 42 USC 300e et seq., subject to an assessment adjustment formula
1304 adopted by the board and approved by the commissioner for such
1305 health care centers [which] that recognizes the restrictions imposed on
1306 such health care centers by federal law. Such adjustment formula shall
1307 be adopted by the board and approved by the commissioner prior to
1308 the first anniversary of the pool's operation.

1309 (B) If such net loss is not recouped before assessments totaling five
1310 per cent of such premiums from plans and arrangements covering
1311 small employers have been collected, additional assessments shall be

1312 apportioned by the board among all members in proportion to their
1313 respective shares of the total health insurance premiums earned in this
1314 state from other individual and group plans and arrangements,
1315 exclusive of any individual Medicare supplement policies as defined in
1316 section 38a-495 during such calendar year.

1317 (C) Notwithstanding the provisions of this subdivision, the
1318 assessments to any one member under subparagraph (A) or (B) of this
1319 subdivision shall not exceed forty per cent of the total assessment
1320 under each subparagraph for the first fiscal year of the pool's operation
1321 and fifty per cent of the total assessment under each subparagraph for
1322 the second fiscal year. Any amounts abated pursuant to this
1323 subparagraph shall be assessed against the other members in a manner
1324 consistent with the basis for assessments set forth in this subdivision.

1325 (3) If assessments exceed actual losses and administrative expenses
1326 of the pool, the excess shall be held at interest and used by the board to
1327 offset future losses or to reduce pool premiums. As used in this
1328 subsection, "future losses" includes reserves for incurred but not
1329 reported claims.

1330 (4) Each member's proportion of participation in the pool shall be
1331 determined annually by the board based on annual statements and
1332 other reports deemed necessary by the board and filed by the member
1333 with it. Insurance arrangements shall report to the board claims
1334 payments made and administrative expenses incurred in this state on
1335 an annual basis on a form prescribed by the commissioner.

1336 (5) Provision shall be made in the plan of operation for the
1337 imposition of an interest penalty for late payment of assessments.

1338 (6) The board may defer, in whole or in part, the assessment of a
1339 health care center if, in the opinion of the board: (A) Payment of the
1340 assessment would endanger the ability of the health care center to
1341 fulfill its contractual obligations, or (B) in accordance with standards
1342 included in the plan of operation, the health care center has written,
1343 and reinsured in their entirety, a disproportionate number of special

1344 health care plans. In the event an assessment against a health care
1345 center is deferred in whole or in part, the amount by which such
1346 assessment is deferred may be assessed against the other members in a
1347 manner consistent with the basis for assessments set forth in this
1348 subsection. The health care center receiving such deferment shall
1349 remain liable to the pool for the amount deferred. The board may
1350 attach appropriate conditions to any such deferment.

1351 [(f) (1) Neither the] (d) (1) The participation in the pool as members,
1352 the establishment of rates, forms or procedures [nor] or any other joint
1353 or collective action required by this section shall not be the basis of any
1354 legal action, criminal or civil liability or penalty against the pool or any
1355 of its members.

1356 (2) Any person or member made a party to any action, suit or
1357 proceeding because the person or member served on the board or on a
1358 committee or was an officer or employee of the pool shall be held
1359 harmless and be indemnified by the program against all liability and
1360 costs, including the amounts of judgments, settlements, fines or
1361 penalties, and expenses and reasonable attorney's fees incurred in
1362 connection with the action, suit or proceeding. The indemnification
1363 shall not be provided on any matter in which the person or member is
1364 finally adjudged in the action, suit or proceeding to have committed a
1365 breach of duty involving gross negligence, dishonesty, wilful
1366 misfeasance or reckless disregard of the responsibilities of office. Costs
1367 and expenses of the indemnification shall be prorated and paid for by
1368 all members. The Insurance Commissioner may retain actuarial
1369 consultants necessary to carry out said commissioner's responsibilities
1370 pursuant to [sections] this section, section 38a-564, as amended by this
1371 act, [to 38a-572, inclusive] 38a-566, as amended by this act, or 38a-567,
1372 as amended by this act, and such expenses shall be paid by the pool
1373 established in this section.

1374 Sec. 10. Section 38a-574 of the general statutes is repealed and the
1375 following is substituted in lieu thereof (*Effective from passage*):

1376 (a) [On or before July 1, 1993, the] The board of directors of the

1377 Connecticut Small Employer Health Reinsurance Pool shall establish,
1378 subject to the approval of the Insurance Commissioner, a standard
1379 [underwriting form] family health statement for use by small employer
1380 carriers [for medical underwriting of health insurance plans and
1381 insurance arrangements covering small employers, as defined in
1382 section 38a-564. Within] to determine whether to cede lives to the
1383 reinsurance pool. Not later than ninety days after approval by the
1384 Insurance Commissioner of the [standard underwriting form] family
1385 health statement, the board shall require every small employer carrier,
1386 as a condition of transacting such business in this state, to use the form
1387 for [medical underwriting of] such plans and arrangements.

1388 (b) The [form] statement may be amended from time to time as the
1389 board deems necessary, subject to the approval of the Insurance
1390 Commissioner.

1391 Sec. 11. Section 38a-537 of the general statutes is repealed and the
1392 following is substituted in lieu thereof (*Effective from passage*):

1393 (a) Any individual, partnership, corporation, or unincorporated
1394 association providing group health insurance coverage for its
1395 employees shall furnish each insured employee, upon cancellation or
1396 discontinuation of such health insurance, notice of the cancellation or
1397 discontinuation of such insurance. The notice shall be mailed or
1398 delivered to the insured employee not less than fifteen days next
1399 preceding the effective date of cancellation or discontinuation. Any
1400 individual or any such entity that fails to provide timely notice shall be
1401 fined not more than two thousand dollars for each violation. The Labor
1402 Commissioner shall have the authority to assess all such fines. This
1403 section shall apply to any such individual, partnership, corporation or
1404 unincorporated association that substitutes one policy providing
1405 group health insurance coverage for another such policy with no
1406 interruption in coverage.

1407 (b) If any individual or any such entity fails to furnish notice
1408 pursuant to subsection (a) of this section, the individual or entity shall
1409 be liable for benefits to the same extent as the insurer, hospital or

1410 medical service corporation or health care center would have been
1411 liable if coverage had not been cancelled or discontinued.

1412 (c) Any individual, partnership, corporation, or unincorporated
1413 association which makes deductions from an employee's wages for
1414 group health insurance coverage and fails to procure such coverage
1415 shall be liable for benefits to the same extent as the insurer, hospital or
1416 medical service corporation or health care center would have been
1417 liable if coverage had been procured. If any corporation makes
1418 deductions from an employee's wages for group health insurance
1419 coverage and fails to procure such coverage, any officer of the
1420 corporation responsible for procuring such coverage for employees
1421 who wilfully failed to procure such coverage shall be personally liable
1422 for benefits to the same extent as the insurer, hospital or medical
1423 service corporation or health care center would have been liable if
1424 coverage had been procured, provided that personal liability shall only
1425 be imposed against the officer in the event that an amount owed an
1426 employee due to the officer's failure cannot otherwise be collected
1427 from the corporation itself.

1428 [(d) Whenever an employer ceases doing business, any terminated
1429 employee whose group health insurance was discontinued on or
1430 before the date of termination of employment and who did not receive
1431 notice of such discontinuation pursuant to subsection (a) of this section
1432 shall be eligible for ninety days from the date of discontinuation to
1433 purchase as a conversion privilege an individual comprehensive health
1434 care plan for himself and any dependents covered by the discontinued
1435 group health insurance plan from the former insurer, hospital or
1436 medical service corporation, health care center or the Health
1437 Reinsurance Association, if any insurer is not issuing such coverage,
1438 with coverage retroactive to the date of discontinuation. The employee
1439 shall pay the premiums for the period of retroactive coverage. No
1440 retroactive coverage may be purchased for a period during which the
1441 employee is eligible for benefits under another group plan.]

1442 Sec. 12. Section 38a-512a of the general statutes is repealed and the

1443 following is substituted in lieu thereof (*Effective from passage*):

1444 (a) (1) Each insurer, health care center, hospital service corporation,
1445 medical service corporation, fraternal benefit society or other entity
1446 delivering, issuing for delivery, renewing, amending or continuing a
1447 group health insurance policy in this state that provides coverage of
1448 the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of
1449 section 38a-469 shall provide the option to continue coverage under
1450 each of the following circumstances until the individual is eligible for
1451 other group insurance, except as provided in subparagraphs (C) and
1452 (D) of this subdivision:

1453 (A) Upon layoff, reduction of hours, leave of absence or termination
1454 of employment, other than as a result of death of the employee or as a
1455 result of such employee's "gross misconduct" as that term is used in 29
1456 USC 1163(2), continuation of coverage for such employee and such
1457 employee's covered dependents for a period of thirty months after the
1458 date of such layoff, reduction of hours, leave of absence or termination
1459 of employment, except that if such reduction of hours, leave of absence
1460 or termination of employment results from an employee's eligibility to
1461 receive Social Security income, continuation of coverage for such
1462 employee and such employee's covered dependents until midnight of
1463 the day preceding such person's eligibility for benefits under Title
1464 XVIII of the Social Security Act;

1465 (B) Upon the death of the employee, continuation of coverage for
1466 the covered dependents of such employee for the periods set forth for
1467 such event under federal extension requirements established by the
1468 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1469 as amended from time to time;

1470 (C) Regardless of the employee's or dependent's eligibility for other
1471 group insurance, during an employee's absence due to illness or injury,
1472 continuation of coverage for such employee and such employee's
1473 covered dependents during continuance of such illness or injury or for
1474 up to twelve months from the beginning of such absence;

1475 (D) Regardless of an individual's eligibility for other group
1476 insurance, upon termination of the group policy, coverage for covered
1477 individuals who were totally disabled on the date of termination shall
1478 be continued without premium payment during the continuance of
1479 such disability for a period of twelve calendar months following the
1480 calendar month in which such policy was terminated, provided claim
1481 is submitted for coverage within one year of the termination of such
1482 policy;

1483 (E) The coverage of any covered individual shall terminate: (i) As to
1484 a child, (I) as set forth in section 38a-512b. If on the date specified for
1485 termination of coverage on a child, the child is incapable of self-
1486 sustaining employment by reason of mental or physical handicap and
1487 chiefly dependent upon the employee for support and maintenance,
1488 the coverage on such child shall continue while the plan remains in
1489 force and the child remains in such condition, provided proof of such
1490 handicap is received by such insurer, center, corporation, society or
1491 other entity within thirty-one days of the date on which the child's
1492 coverage would have terminated in the absence of such incapacity.
1493 Such insurer, center, corporation, society or other entity may require
1494 subsequent proof of the child's continued incapacity and dependency
1495 but not more often than once a year thereafter, or (II) for the periods
1496 set forth for such child under federal extension requirements
1497 established by the Consolidated Omnibus Budget Reconciliation Act of
1498 1985, P.L. 99-272, as amended from time to time; (ii) as to the
1499 employee's spouse, at the end of the month following the month in
1500 which a divorce, court-ordered annulment or legal separation is
1501 obtained, whichever is earlier, except that the plan shall provide the
1502 option for said spouse to continue coverage for the periods set forth for
1503 such events under federal extension requirements established by the
1504 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
1505 as amended from time to time; and (iii) as to the employee or
1506 dependent who is sixty-five years of age or older, as of midnight of the
1507 day preceding such person's eligibility for benefits under Title XVIII of
1508 the federal Social Security Act;

1509 (F) As to any other event listed as a "qualifying event" in 29 USC
1510 1163, as amended from time to time, continuation of coverage for such
1511 periods set forth for such event in 29 USC 1162, as amended from time
1512 to time, provided such plan may require the individual whose
1513 coverage is to be continued to pay up to the percentage of the
1514 applicable premium as specified for such event in 29 USC 1162, as
1515 amended from time to time.

1516 (2) Any continuation of coverage required by this subsection except
1517 subparagraph (D) or (F) of subdivision (1) of this subsection may be
1518 subject to the requirement, on the part of the individual whose
1519 coverage is to be continued, that such individual contribute that
1520 portion of the premium the individual would have been required to
1521 contribute had the employee remained an active covered employee,
1522 except that the individual may be required to pay up to one hundred
1523 two per cent of the entire premium at the group rate if coverage is
1524 continued in accordance with subparagraph (A), (B) or (E) of
1525 subdivision (1) of this subsection. The employer shall not be legally
1526 obligated by section 38a-505, as amended by this act, or 38a-546 to pay
1527 such premium if not paid timely by the employee.

1528 [(b) The plan shall make available to Connecticut residents, in
1529 addition to any other conversion privilege available, a conversion
1530 privilege under which coverage shall be available immediately upon
1531 termination of coverage under the group policy. The terms and
1532 benefits offered under the conversion benefits shall be at least equal to
1533 the terms and benefits of an individual health insurance policy.]

1534 [(c)] (b) Nothing in this section shall alter or impair existing group
1535 policies which have been established pursuant to an agreement which
1536 resulted from collective bargaining, and the provisions required by
1537 this section shall become effective upon the next regular renewal and
1538 completion of such collective bargaining agreement.

1539 Sec. 13. Subsection (f) of section 5-248a of the 2014 supplement to
1540 the general statutes is repealed and the following is substituted in lieu
1541 thereof (*Effective from passage*):

1542 (f) [Notwithstanding the provisions of subsection (b) of section 38a-
1543 554, the] The state shall pay for the continuation of health insurance
1544 benefits for the employee during any leave of absence taken pursuant
1545 to this section. In order to continue any other health insurance
1546 coverages during such leave, the employee shall contribute that
1547 portion of the premium the employee would have been required to
1548 contribute had the employee remained an active employee during the
1549 leave period.

1550 Sec. 14. Subsection (i) of section 5-259 of the 2014 supplement to the
1551 general statutes is repealed and the following is substituted in lieu
1552 thereof (*Effective from passage*):

1553 (i) The Comptroller may provide for coverage of employees of
1554 municipalities, nonprofit corporations, community action agencies and
1555 small employers and individuals eligible for a health coverage tax
1556 credit, retired members or members of an association for personal care
1557 assistants under the plan or plans procured under subsection (a) of this
1558 section, provided: (1) Participation by each municipality, nonprofit
1559 corporation, community action agency, small employer, eligible
1560 individual, retired member or association for personal care assistants
1561 shall be on a voluntary basis; (2) where an employee organization
1562 represents employees of a municipality, nonprofit corporation,
1563 community action agency or small employer, participation in a plan or
1564 plans to be procured under subsection (a) of this section shall be by
1565 mutual agreement of the municipality, nonprofit corporation,
1566 community action agency or small employer and the employee
1567 organization only and neither party may submit the issue of
1568 participation to binding arbitration except by mutual agreement if
1569 such binding arbitration is available; (3) no group of employees shall
1570 be refused entry into the plan by reason of past or future health care
1571 costs or claim experience; (4) rates paid by the state for its employees
1572 under subsection (a) of this section are not adversely affected by this
1573 subsection; (5) administrative costs to the plan or plans provided
1574 under this subsection shall not be paid by the state; (6) participation in
1575 the plan or plans in an amount determined by the state shall be for the

1576 duration of the period of the plan or plans, or for such other period as
1577 mutually agreed by the municipality, nonprofit corporation,
1578 community action agency, small employer, retired member or
1579 association for personal care assistants and the Comptroller; and (7)
1580 nothing in this section or section 12-202a, 38a-551, as amended by this
1581 act, [38a-553] or 38a-556, as amended by this act, shall be construed as
1582 requiring a participating insurer or health care center to issue
1583 individual policies to individuals eligible for a health coverage tax
1584 credit. The coverage provided under this section may be referred to as
1585 the "Municipal Employee Health Insurance Plan". The Comptroller
1586 may arrange and procure for the employees and eligible individuals
1587 under this subsection health benefit plans that vary from the plan or
1588 plans procured under subsection (a) of this section. Notwithstanding
1589 any provision of part V of chapter 700c, the coverage provided under
1590 this subsection may be offered on either a fully underwritten or risk-
1591 pooled basis at the discretion of the Comptroller. For the purposes of
1592 this subsection, (A) "municipality" means any town, city, borough,
1593 school district, taxing district, fire district, district department of
1594 health, probate district, housing authority, regional work force
1595 development board established under section 31-3k, regional
1596 emergency telecommunications center, tourism district established
1597 under section 32-302, flood commission or authority established by
1598 special act, regional planning agency, transit district formed under
1599 chapter 103a, or the Children's Center established by number 571 of
1600 the public acts of 1969; (B) "nonprofit corporation" means (i) a
1601 nonprofit corporation organized under 26 USC 501 that has a contract
1602 with the state or receives a portion of its funding from a municipality,
1603 the state or the federal government, or (ii) an organization that is tax
1604 exempt pursuant to 26 USC 501(c)(5); (C) "community action agency"
1605 means a community action agency, as defined in section 17b-885; (D)
1606 "small employer" means a small employer, as defined in
1607 [subparagraph (A) of subdivision (4) of] section 38a-564, as amended
1608 by this act; (E) "eligible individuals" or "individuals eligible for a health
1609 coverage tax credit" means individuals who are eligible for the credit
1610 for health insurance costs under Section 35 of the Internal Revenue

1611 Code of 1986, or any subsequent corresponding internal revenue code
1612 of the United States, as from time to time amended, in accordance with
1613 the Pension Benefit Guaranty Corporation; [and Trade Adjustment
1614 Assistance programs of the Trade Act of 2002 (P.L. 107-210);] (F)
1615 "association for personal care assistants" means an organization
1616 composed of personal care attendants who are employed by recipients
1617 of service (i) under the home-care program for the elderly under
1618 section 17b-342, (ii) under the personal care assistance program under
1619 section 17b-605a, (iii) in an independent living center pursuant to
1620 sections 17b-613 to 17b-615, inclusive, or (iv) under the program for
1621 individuals with acquired brain injury as described in section 17b-
1622 260a; and (G) "retired members" means individuals eligible for a
1623 retirement benefit from the Connecticut municipal employees'
1624 retirement system.

1625 Sec. 15. Subsection (i) of section 5-259 of the 2014 supplement to the
1626 general statutes, as amended by section 266 of public act 13-247, is
1627 repealed and the following is substituted in lieu thereof (*Effective*
1628 *January 1, 2015*):

1629 (i) The Comptroller may provide for coverage of employees of
1630 municipalities, nonprofit corporations, community action agencies and
1631 small employers and individuals eligible for a health coverage tax
1632 credit, retired members or members of an association for personal care
1633 assistants under the plan or plans procured under subsection (a) of this
1634 section, provided: (1) Participation by each municipality, nonprofit
1635 corporation, community action agency, small employer, eligible
1636 individual, retired member or association for personal care assistants
1637 shall be on a voluntary basis; (2) where an employee organization
1638 represents employees of a municipality, nonprofit corporation,
1639 community action agency or small employer, participation in a plan or
1640 plans to be procured under subsection (a) of this section shall be by
1641 mutual agreement of the municipality, nonprofit corporation,
1642 community action agency or small employer and the employee
1643 organization only and neither party may submit the issue of
1644 participation to binding arbitration except by mutual agreement if

1645 such binding arbitration is available; (3) no group of employees shall
1646 be refused entry into the plan by reason of past or future health care
1647 costs or claim experience; (4) rates paid by the state for its employees
1648 under subsection (a) of this section are not adversely affected by this
1649 subsection; (5) administrative costs to the plan or plans provided
1650 under this subsection shall not be paid by the state; (6) participation in
1651 the plan or plans in an amount determined by the state shall be for the
1652 duration of the period of the plan or plans, or for such other period as
1653 mutually agreed by the municipality, nonprofit corporation,
1654 community action agency, small employer, retired member or
1655 association for personal care assistants and the Comptroller; and (7)
1656 nothing in this section or section 12-202a, 38a-551, as amended by this
1657 act, [38a-553] or 38a-556, as amended by this act, shall be construed as
1658 requiring a participating insurer or health care center to issue
1659 individual policies to individuals eligible for a health coverage tax
1660 credit. The coverage provided under this section may be referred to as
1661 the "Municipal Employee Health Insurance Plan". The Comptroller
1662 may arrange and procure for the employees and eligible individuals
1663 under this subsection health benefit plans that vary from the plan or
1664 plans procured under subsection (a) of this section. Notwithstanding
1665 any provision of part V of chapter 700c, the coverage provided under
1666 this subsection may be offered on either a fully underwritten or risk-
1667 pooled basis at the discretion of the Comptroller. For the purposes of
1668 this subsection, (A) "municipality" means any town, city, borough,
1669 school district, taxing district, fire district, district department of
1670 health, probate district, housing authority, regional work force
1671 development board established under section 31-3k, regional
1672 emergency telecommunications center, tourism district established
1673 under section 32-302, flood commission or authority established by
1674 special act, regional council of governments, transit district formed
1675 under chapter 103a, or the Children's Center established by number
1676 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a
1677 nonprofit corporation organized under 26 USC 501 that has a contract
1678 with the state or receives a portion of its funding from a municipality,
1679 the state or the federal government, or (ii) an organization that is tax

1680 exempt pursuant to 26 USC 501(c)(5); (C) "community action agency"
1681 means a community action agency, as defined in section 17b-885; (D)
1682 "small employer" means a small employer, as defined in
1683 [subparagraph (A) of subdivision (4) of] section 38a-564, as amended
1684 by this act; (E) "eligible individuals" or "individuals eligible for a health
1685 coverage tax credit" means individuals who are eligible for the credit
1686 for health insurance costs under Section 35 of the Internal Revenue
1687 Code of 1986, or any subsequent corresponding internal revenue code
1688 of the United States, as from time to time amended, in accordance with
1689 the Pension Benefit Guaranty Corporation; [and Trade Adjustment
1690 Assistance programs of the Trade Act of 2002 (P. L. 107-210);] (F)
1691 "association for personal care assistants" means an organization
1692 composed of personal care attendants who are employed by recipients
1693 of service (i) under the home-care program for the elderly under
1694 section 17b-342, (ii) under the personal care assistance program under
1695 section 17b-605a, (iii) in an independent living center pursuant to
1696 sections 17b-613 to 17b-615, inclusive, or (iv) under the program for
1697 individuals with acquired brain injury as described in section 17b-
1698 260a; and (G) "retired members" means individuals eligible for a
1699 retirement benefit from the Connecticut municipal employees'
1700 retirement system.

1701 Sec. 16. Subdivision (7) of section 12-201 of the general statutes is
1702 repealed and the following is substituted in lieu thereof (*Effective from*
1703 *passage*):

1704 (7) "Gross direct premiums" means all receipts of premiums from
1705 policyholders and applicants for policies, whether received in the form
1706 of money or other valuable consideration, but excluding annuity
1707 premiums and considerations and premiums received for reinsurances
1708 assumed from other insurance companies; [and premiums received
1709 after July 1, 1990, and before January 1, 1995, for any special health
1710 care plan, as defined in section 38a-564;]

1711 Sec. 17. Subsection (c) of section 12-211 of the general statutes is
1712 repealed and the following is substituted in lieu thereof (*Effective from*

1713 *passage*):

1714 (c) The provisions of this section shall not apply to ad valorem taxes
1715 on real or personal property, personal income taxes, fees for agents'
1716 licenses, special purpose assessments imposed in connection with
1717 particular kinds of insurance including, but not limited to, workers'
1718 compensation assessments and Insurance Guaranty Association Fund
1719 assessments, or to premium taxes on special health care plans as
1720 defined in [section] sections 38a-564, revision of 1958, revised to
1721 January 1, 2013, and 38a-551, as amended by this act, except in the case
1722 where another state or foreign country imposes upon Connecticut
1723 domiciled insurers retaliatory charges for such taxes, fees or
1724 assessments.

1725 Sec. 18. Section 12-212a of the general statutes is repealed and the
1726 following is substituted in lieu thereof (*Effective from passage*):

1727 All corporations organized under sections 38a-199 to 38a-209,
1728 inclusive, and 38a-214 to 38a-225, inclusive, shall pay to the
1729 Commissioner of Revenue Services on or before March first, annually,
1730 a charge at the rate of two per cent of the total net direct subscriber
1731 charges [, excluding those net direct subscriber charges received after
1732 July 1, 1990, and before January 1, 1995, from employers for any special
1733 health care plan, as defined in section 38a-564,] received by such
1734 corporation during the next preceding calendar year, which shall be in
1735 addition to any other payment required under section 38a-48. The
1736 charge required under this section and any other payment required
1737 under said section 38a-48 shall be in compensation for the costs and
1738 expenses of regulation by the Insurance Department and all other
1739 governmental services. The provisions of this chapter pertaining to the
1740 filing of returns, declarations, assessment and collection of taxes, and
1741 penalties imposed on domestic insurance companies shall apply with
1742 respect to the charge imposed under this section, provided
1743 corporations subject to the charge imposed under this section shall not
1744 be subject to any tax imposed under this chapter.

1745 Sec. 19. Subsection (e) of section 17b-265 of the general statutes is

1746 repealed and the following is substituted in lieu thereof (*Effective from*
1747 *passage*):

1748 (e) [Notwithstanding the provisions of subsection (c) of section 38a-
1749 553, no] No self-insured plan, group health plan, as defined in Section
1750 607(1) of the Employee Retirement Income Security Act of 1974, service
1751 benefit plan, managed care plan, or any plan offered or administered
1752 by a health care center, pharmacy benefit manager, dental benefit
1753 manager, third-party administrator or other party that is, by statute,
1754 contract or agreement, legally responsible for payment of a claim for a
1755 health care item or service, shall contain any provision that has the
1756 effect of denying or limiting enrollment benefits or excluding coverage
1757 because services are rendered to an insured or beneficiary who is
1758 eligible for or who received medical assistance under this chapter. No
1759 insurer, as defined in section 38a-497a, shall impose requirements on
1760 the state Medicaid agency, which has been assigned the rights of an
1761 individual eligible for Medicaid and covered for health benefits from
1762 an insurer, that differ from requirements applicable to an agent or
1763 assignee of another individual so covered.

1764 Sec. 20. Subsection (c) of section 17b-284 of the general statutes is
1765 repealed and the following is substituted in lieu thereof (*Effective from*
1766 *passage*):

1767 (c) The commissioner may pay under the Medicaid program, within
1768 available appropriations, the premiums for continued health insurance
1769 coverage under an employer's group health insurance plan, pursuant
1770 to section [38a-554] 38a-512a, as amended by this act, for chronically ill
1771 and disabled persons who are no longer employed and would
1772 otherwise be eligible for Medicaid.

1773 Sec. 21. Subdivision (6) of subsection (c) of section 17b-299 of the
1774 general statutes is repealed and the following is substituted in lieu
1775 thereof (*Effective from passage*):

1776 (6) Expiration of the continuation of coverage periods set forth in
1777 section [38a-554] 38a-512a, as amended by this act;

1778 Sec. 22. Subsection (b) of section 17b-611 of the general statutes is
1779 repealed and the following is substituted in lieu thereof (*Effective from*
1780 *passage*):

1781 (b) The contract shall provide the same benefits as are provided
1782 under contracts issued pursuant to sections 38a-505, as amended by
1783 this act, 38a-546, 38a-551, as amended by this act, and 38a-556 to 38a-
1784 559, inclusive, as amended by this act, except mental and nervous
1785 disorders shall be covered in accordance with section 38a-514.

1786 Sec. 23. Subsection (b) of section 19a-7b of the general statutes is
1787 repealed and the following is substituted in lieu thereof (*Effective from*
1788 *passage*):

1789 (b) The commission shall develop the design, administrative,
1790 actuarial and financing details of program initiatives necessary to
1791 attain the goal described in section 19a-7a. [The commission shall
1792 study the experience of the state under the programs and policies
1793 developed pursuant to sections 12-201, 12-211, 12-212a, 17b-277, 17b-
1794 282 to 17b-284, inclusive, 17b-611, 19a-7a to 19a-7d, inclusive,
1795 subsection (a) of 19a-59b, subsection (b) of section 38a-552, subsection
1796 (d) of section 38a-556 and sections 38a-564 to 38a-573, inclusive, and
1797 shall make interim reports to the General Assembly on its findings by
1798 January 15, 1991, and by February 1, 1992, and a final report on such
1799 findings by February 1, 1993.] The commission shall make
1800 recommendations to the General Assembly on any legislation
1801 necessary to further the attainment of the goal described in section 19a-
1802 7a.

1803 Sec. 24. Subsection (a) of section 31-51o of the general statutes is
1804 repealed and the following is substituted in lieu thereof (*Effective from*
1805 *passage*):

1806 (a) Whenever a relocation or closing of a covered establishment
1807 occurs, the employer of the covered establishment shall pay in full for
1808 the continuation of existing group health insurance, no matter where
1809 the group policy was written, issued or delivered, for each affected

1810 employee and his dependents, if covered under the group policy, from
1811 the date of relocation or closing for a period of one hundred twenty
1812 days or until such time as the employee becomes eligible for other
1813 group coverage, whichever is the lesser, provided any right of such
1814 employee and his dependents to a continuation of coverage, as
1815 required by section [38a-538 or 38a-554] 38a-512a, as amended by this
1816 act, shall not be affected by the provisions of this section, and provided
1817 further the period of continued coverage required by said sections
1818 shall not commence until the period of continued coverage established
1819 by this section has terminated.

1820 Sec. 25. Section 38a-472d of the general statutes is repealed and the
1821 following is substituted in lieu thereof (*Effective from passage*):

1822 (a) Not later than January 1, 2006, the Insurance Commissioner, in
1823 consultation with the Commissioner of Social Services and the
1824 Healthcare Advocate, shall develop a comprehensive public education
1825 outreach program to educate health insurance consumers about the
1826 availability and general eligibility requirements of various health
1827 insurance options in this state. The program shall maximize public
1828 information concerning health insurance options in this state and shall
1829 provide for the dissemination of such information on the Insurance
1830 Department's Internet web site.

1831 (b) The information on the department's Internet web site shall
1832 reference the availability and general eligibility requirements of (1)
1833 programs administered by the Department of Social Services,
1834 including, but not limited to, the Medicaid program and the HUSKY
1835 Plan, Part A and Part B, (2) health insurance coverage provided by the
1836 Comptroller under subsection (i) of section 5-259, as amended by this
1837 act, [(3) health insurance coverage available under comprehensive
1838 health care plans issued pursuant to part IV of this chapter, and (4)]
1839 and (3) other health insurance coverage offered through local, state or
1840 federal agencies or through entities licensed in this state. The
1841 commissioner shall update the information on the web site at least
1842 quarterly.

1843 Sec. 26. Section 38a-505 of the general statutes is repealed and the
1844 following is substituted in lieu thereof (*Effective from passage*):

1845 In order to provide reasonable simplification of terms and coverages
1846 of individual health insurance policies, to facilitate public
1847 understanding and comparison, to eliminate provisions [which] that
1848 may be misleading or unreasonably confusing in connection with
1849 either the purchase of such coverage or with the settlement of claims
1850 and to provide for full disclosure in the sale of such coverages:

1851 [(a)] (1) The commissioner shall [issue] adopt regulations, in
1852 accordance with the provisions of chapter 54, to establish specific
1853 standards for policy provisions used in individual health insurance
1854 policies, [but not including group conversion policies, which] that shall
1855 be in addition to and in accordance with sections 38a-80, 38a-321 to
1856 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
1857 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
1858 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
1859 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, and other
1860 applicable laws of this state [which] that may cover the terms of
1861 renewability, initial and subsequent conditions of eligibility,
1862 nonduplication of coverage provisions, coverage of dependents,
1863 termination of insurance, probationary periods, limitations, exceptions,
1864 reductions, elimination periods, requirements for replacements,
1865 recurrent conditions, preexisting conditions [,] and the definition of the
1866 terms hospital, accident, sickness, injury, physician, accidental means,
1867 total disability, permanent disability, partial disability, nervous
1868 disorders, guaranteed renewable [,] and noncancellable.

1869 [(b)] (2) The commissioner shall adopt regulations, in accordance
1870 with chapter 54, that specify prohibited policy provisions not
1871 otherwise specifically authorized by statute [which] that, in the
1872 opinion of the commissioner, are unjust, unfair or unfairly
1873 discriminatory to the policyholder, any person insured under the
1874 policy [,] or any beneficiary.

1875 [(c)] (3) The commissioner shall adopt regulations, in accordance

1876 with chapter 54, to establish minimum standards for benefits under
1877 each of the following categories of coverage in individual policies: [,
1878 other than conversion policies issued pursuant to a contractual
1879 conversion privilege under a group policy:] Basic hospital expense
1880 coverage, basic medical-surgical expense coverage, hospital
1881 confinement indemnity coverage, major medical expense coverage,
1882 disability income protection coverage, accident only coverage,
1883 specified accident coverage and specified disease coverage.

1884 [(d)] (4) Nothing in this section shall preclude the issuance of any
1885 policy [which] that combines two or more of the categories of coverage
1886 enumerated in [subsection (c)] subdivision (3) of this section, except
1887 that specified accident coverage shall not be combined with any other
1888 category of coverage. The commissioner shall prescribe the method of
1889 identification of policies based upon coverage provided.

1890 [(e)] (5) No policy shall be delivered or issued for delivery in this
1891 state [which] that does not meet the prescribed minimum standards for
1892 the categories of coverage listed in [subsection (c)] subdivision (3) of
1893 this section, provided nothing in this section shall preclude the
1894 issuance or delivery of any policy [which] that does not meet such
1895 prescribed minimum standards of coverage so long as such policy is
1896 clearly identified as not meeting such prescribed standards.

1897 [(f)] (6) No such policy shall be delivered in this state unless: [(1)]
1898 (A) An outline of coverage described herein accompanies the policy or
1899 [(2)] (B) the outline of coverage described in this section is delivered to
1900 the applicant at the time application is made and acknowledgment of
1901 receipt of certificate of delivery of such outline is provided the carrier
1902 with the application. In the event the policy is issued on a basis other
1903 than that applied for, the outline of coverage properly describing the
1904 policy shall accompany the policy when it is delivered. The outline of
1905 coverage shall include: [(A)] (i) A statement identifying the applicable
1906 category or categories of coverage provided by the policy in
1907 accordance with this section; [(B)] (ii) a description of the principal
1908 benefits and coverage provided in the policy; [(C)] (iii) a statement of

1909 the exceptions, reductions and limitations contained in the policy or
1910 contract; [(D)] (iv) a statement of the renewal provisions including any
1911 reservation by the carrier of a right to change premiums; and [(E)] (v) a
1912 statement that the outline is a summary of the policy issued or applied
1913 for and that the policy should be consulted to determine governing
1914 contractual provisions.

1915 [(g) Notwithstanding the provisions of sections 38a-80, 38a-321 to
1916 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
1917 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
1918 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
1919 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, if a carrier
1920 elects to use a simplified application form, with or without any
1921 questions as to the applicant's health at the time of application, but
1922 without any questions concerning the insured's health history or
1923 medical treatment history, the policy shall cover loss developing after
1924 twelve months from any preexisting condition not specifically
1925 excluded from coverage by the terms of the policy and, except as so
1926 provided, the policy shall not include wording that would permit a
1927 defense based upon preexisting conditions.]

1928 [(h)] (7) Regulations promulgated pursuant to this section shall
1929 specify an effective date applicable to policy and benefit riders
1930 delivered or issued for delivery in this state on and after such effective
1931 date [which] that shall not be less than one hundred eighty days after
1932 the date of adoption or promulgation.

1933 Sec. 27. Section 38a-573 of the general statutes is repealed and the
1934 following is substituted in lieu thereof (*Effective from passage*):

1935 If any provision of [sections] section 38a-564, as amended by this
1936 act, [to 38a-572, inclusive] 38a-566, as amended by this act, 38a-567, as
1937 amended by this act, or 38a-569, as amended by this act, is held
1938 invalid, the invalidity shall not affect other provisions of said sections
1939 [which] that can be given effect without the invalid provisions.

1940 Sec. 28. Section 38a-476 of the general statutes is repealed and the

1941 following is substituted in lieu thereof (*Effective from passage*):

1942 (a) [(1)] For the purposes of this section: [, "health]

1943 (1) "Health insurance plan" means any hospital and medical expense
1944 incurred policy, hospital or medical service plan contract and health
1945 care center subscriber contract. [and] "Health insurance plan" does not
1946 include (A) short-term health insurance issued on a nonrenewable
1947 basis with a duration of six months or less, accident only, credit,
1948 dental, vision, Medicare supplement, long-term care or disability
1949 insurance, hospital indemnity coverage, coverage issued as a
1950 supplement to liability insurance, insurance arising out of a workers'
1951 compensation or similar law, automobile medical payments insurance,
1952 or insurance under which beneficiaries are payable without regard to
1953 fault and which is statutorily required to be contained in any liability
1954 insurance policy or equivalent self-insurance, or (B) policies of
1955 specified disease or limited benefit health insurance, provided that the
1956 carrier offering such policies files on or before March first of each year
1957 a certification with the Insurance Commissioner that contains the
1958 following: (i) A statement from the carrier certifying that such policies
1959 are being offered and marketed as supplemental health insurance and
1960 not as a substitute for hospital or medical expense insurance; (ii) a
1961 summary description of each such policy including the average annual
1962 premium rates, or range of premium rates in cases where premiums
1963 vary by age, gender or other factors, charged for such policies in the
1964 state; and (iii) in the case of a policy that is described in this
1965 subparagraph and that is offered for the first time in this state on or
1966 after October 1, 1993, the carrier files with the commissioner the
1967 information and statement required in this subparagraph at least thirty
1968 days prior to the date such policy is issued or delivered in this state.

1969 (2) "Insurance arrangement" means any "multiple employer welfare
1970 arrangement", as defined in Section 3 of the Employee Retirement
1971 Income Security Act of 1974, [(ERISA),] as amended from time to time,
1972 except for any such arrangement [which] that is fully insured within
1973 the meaning of Section 514(b)(6) of said act, as amended from time to

1974 time.

1975 (3) "Preexisting conditions provision" means a policy provision
1976 [which] that limits or excludes benefits relating to a condition based on
1977 the fact that the condition was present before the effective date of
1978 coverage, for which any medical advice, diagnosis, care or treatment
1979 was recommended or received before such effective date. Routine
1980 follow-up care to determine whether a breast cancer has reoccurred in
1981 a person who has been previously determined to be breast cancer free
1982 shall not be considered as medical advice, diagnosis, care or treatment
1983 for purposes of this section unless evidence of breast cancer is found
1984 during or as a result of such follow-up. Genetic information shall not
1985 be treated as a condition in the absence of a diagnosis of the condition
1986 related to such information. Pregnancy shall not be considered a
1987 preexisting condition.

1988 [(4) "Qualifying coverage" means (A) any group health insurance
1989 plan, insurance arrangement or self-insured plan, (B) Medicare or
1990 Medicaid, or (C) an individual health insurance plan that provides
1991 benefits which are actuarially equivalent to or exceeding the benefits
1992 provided under the small employer health care plan, as defined in
1993 subdivision (12) of section 38a-564, whether issued in this state or any
1994 other state.]

1995 [(5)] (4) "Applicable waiting period" means the period of time
1996 imposed by the group policyholder or contractholder before an
1997 individual is eligible for participating in the group policy or contract.

1998 (b) (1) No group health insurance plan or insurance arrangement
1999 shall impose a preexisting conditions provision [that excludes
2000 coverage for (A) individuals eighteen years of age and younger, or (B)
2001 a period beyond twelve months following the insured's effective date
2002 of coverage. Any preexisting conditions provision shall only relate to
2003 conditions, whether physical or mental, for which medical advice,
2004 diagnosis or care or treatment was recommended or received during
2005 the six months immediately preceding the effective date of coverage]
2006 on any individual.

2007 (2) No individual health insurance plan or insurance arrangement
2008 shall impose a preexisting conditions provision [that excludes
2009 coverage for (A) individuals eighteen years of age and younger, or (B)
2010 a period beyond twelve months following the insured's effective date
2011 of coverage. Any preexisting conditions provision shall only relate to
2012 conditions, whether physical or mental, for which medical advice,
2013 diagnosis or care or treatment was recommended or received during
2014 the twelve months immediately preceding the effective date of
2015 coverage] on any individual.

2016 (3) No insurance company, fraternal benefit society, hospital service
2017 corporation, medical service corporation or health care center shall
2018 refuse to issue an individual health insurance plan or insurance
2019 arrangement to [individuals eighteen years of age and younger] any
2020 individual solely on the basis that [an] such individual has a
2021 preexisting condition.

2022 [(c) All health insurance plans and insurance arrangements shall
2023 provide coverage, under the terms and conditions of their policies or
2024 contracts, for the preexisting conditions of any newly insured
2025 individual who was previously covered for such preexisting condition
2026 under the terms of the individual's preceding qualifying coverage,
2027 provided the preceding coverage was continuous to a date less than
2028 one hundred twenty days prior to the effective date of the new
2029 coverage, exclusive of any applicable waiting period, except in the case
2030 of a newly insured group member whose previous coverage was
2031 terminated due to an involuntary loss of employment, the preceding
2032 coverage must have been continuous to a date not more than one
2033 hundred fifty days prior to the effective date of the new coverage,
2034 exclusive of any applicable waiting period, provided such newly
2035 insured group member or dependent applies for such succeeding
2036 coverage within thirty days of the member's or dependent's initial
2037 eligibility.

2038 (d) With respect to a newly insured individual who was previously
2039 covered under qualifying coverage, but who was not covered under

2040 such qualifying coverage for a preexisting condition, as defined under
2041 the new health insurance plan or arrangement, such plan or
2042 arrangement shall credit the time such individual was previously
2043 covered by qualifying coverage to the exclusion period of the
2044 preexisting condition provision, provided the preceding coverage was
2045 continuous to a date less than one hundred twenty days prior to the
2046 effective date of the new coverage, exclusive of any applicable waiting
2047 period under such plan, except in the case of a newly insured group
2048 member whose preceding coverage was terminated due to an
2049 involuntary loss of employment, the preceding coverage must have
2050 been continuous to a date not more than one hundred fifty days prior
2051 to the effective date of the new coverage, exclusive of any applicable
2052 waiting period, provided such newly insured group member or
2053 dependent applies for such succeeding coverage within thirty days of
2054 the member's or dependent's initial eligibility.

2055 (e) Each insurance company, fraternal benefit society, hospital
2056 service corporation, medical service corporation or health care center
2057 which issues in this state group health insurance subject to Section
2058 2701 of the Public Health Service Act, as set forth in the Health
2059 Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
2060 (HIPAA), as amended from time to time, shall comply with the
2061 provisions of said section with respect to such group health insurance,
2062 except that the longer period of days specified in subsections (c) and
2063 (d) of this section shall apply to the extent excepted from preemption
2064 in Section 2723(B)(2)(iii) of said Public Health Service Act.

2065 (f) The provisions of this section shall apply to every health
2066 insurance plan or insurance arrangement issued, renewed or
2067 continued in this state on or after October 1, 1993. For purposes of this
2068 section, the date a plan or arrangement is continued shall be the
2069 anniversary date of the issuance of the plan or arrangement. The
2070 provisions of subsection (e) of this section shall apply on and after the
2071 dates specified in Sections 2747 and 2792 of the Public Health Service
2072 Act as set forth in HIPAA.]

2073 [(g)] (c) (1) Notwithstanding the provisions of subsection (a) of this
2074 section, a short-term health insurance policy issued on a nonrenewable
2075 basis for six months or less [which] that imposes a preexisting
2076 conditions provision shall be subject to the following conditions: [(1)]
2077 (A) No such preexisting conditions provision shall exclude coverage
2078 beyond twelve months following the insured's effective date of
2079 coverage; [(2)] (B) such preexisting conditions provision may only
2080 relate to conditions, whether physical or mental, for which medical
2081 advice, diagnosis, care or treatment was recommended or received
2082 during the twenty-four months immediately preceding the effective
2083 date of coverage; and [(3)] (C) any policy, application or sales brochure
2084 issued for such short-term health insurance policy that imposes such
2085 preexisting conditions provision shall disclose in a conspicuous
2086 manner in not less than fourteen-point bold face type the following
2087 statement:

2088 "THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR
2089 WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT
2090 WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-
2091 FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE
2092 DATE OF COVERAGE."

2093 (2) In the event an insurer or health care center issues two
2094 consecutive short-term health insurance policies on a nonrenewable
2095 basis for six months or less [which imposes] that impose a preexisting
2096 conditions provision to the same individual, the insurer or health care
2097 center shall reduce the preexisting conditions exclusion period in the
2098 second policy by the period of time such individual was covered under
2099 the first policy. If the same insurer or health care center issues a third
2100 or subsequent such short-term health insurance policy to the same
2101 individual, such insurer or health care center shall reduce the
2102 preexisting conditions exclusion period in the third or subsequent
2103 policy by the cumulative time covered under the prior policies.
2104 Nothing in this section shall be construed to require such short-term
2105 health insurance policy to be issued on a guaranteed issue or
2106 guaranteed renewable basis.

2107 [(h) The commissioner may adopt regulations, in accordance with
2108 the provisions of chapter 54, to enforce the provisions of HIPAA and
2109 this section concerning preexisting conditions and portability.]

2110 Sec. 29. Section 38a-513 of the general statutes is repealed and the
2111 following is substituted in lieu thereof (*Effective from passage*):

2112 (a) (1) No group health insurance policy, as defined by the
2113 commissioner, or certificate shall be issued or delivered in this state
2114 unless a copy of the form for such policy or certificate has been
2115 submitted to and approved by the commissioner under the regulations
2116 adopted pursuant to this section. The commissioner shall adopt
2117 regulations, in accordance with chapter 54, concerning the provisions,
2118 submission and approval of such policies and certificates and
2119 establishing a procedure for reviewing such policies and certificates. If
2120 the commissioner issues an order disapproving the use of such form,
2121 the provisions of section 38a-19 shall apply to such order.

2122 (2) No group health insurance policy or certificate for a small
2123 employer, as defined in section 38a-564, as amended by this act, shall
2124 be issued or delivered in this state unless the premium rates have been
2125 submitted to and approved by the commissioner. Premium rate filings
2126 shall include an actuarial memorandum that includes, but is not
2127 limited to, (A) pricing assumptions and claims experience, and (B)
2128 premium rates and loss ratios from the inception of the policy.

2129 (b) No insurance company, fraternal benefit society, hospital service
2130 corporation, medical service corporation, health care center or other
2131 entity [which] that delivers or issues for delivery in this state any
2132 Medicare supplement policies or certificates shall incorporate in its
2133 rates or determinations to grant coverage for Medicare supplement
2134 insurance policies or certificates any factors or values based on the age,
2135 gender, previous claims history or the medical condition of any person
2136 covered by such policy or certificate.

2137 (c) Nothing in this chapter shall preclude the issuance of a group
2138 health insurance policy [which] that includes an optional life insurance

2139 rider, provided the optional life insurance rider must be filed with and
2140 approved by the Insurance Commissioner pursuant to section 38a-430.
2141 Any company offering such policies for sale in this state shall be
2142 licensed to sell life insurance in this state pursuant to the provisions of
2143 section 38a-41.

2144 (d) Not later than January 1, 2009, the commissioner shall adopt
2145 regulations, in accordance with chapter 54, to establish minimum
2146 standards for benefits in group specified disease policies, certificates,
2147 riders, endorsements and benefits.

2148 Sec. 30. Section 38a-543 of the general statutes is repealed and the
2149 following is substituted in lieu thereof (*Effective from passage*):

2150 [No individual, partnership, corporation or unincorporated
2151 association which employs less than twenty employees and provides
2152 group hospital, surgical or medical insurance coverage for its
2153 employees may reduce the coverage provided to any employee or any
2154 employee's spouse solely because he has reached the age of sixty-five
2155 and is eligible for Medicare benefits except to the extent such coverage
2156 is provided by Medicare. The terms of any such plan provided by any
2157 such employer which employs twenty or more employees shall entitle
2158 any employee who has attained the age of sixty-five and any
2159 employee's spouse who has attained the age of sixty-five to group
2160 hospital, surgical or medical insurance coverage under the same
2161 conditions as any covered employee or spouse who is under the age of
2162 sixty-five.] No group health insurance policy delivered, issued for
2163 delivery, renewed, amended or continued in this state shall include
2164 any provision that reduces payments on the basis that an individual is
2165 eligible for Medicare by reason of age, disability or end-stage renal
2166 disease, unless such individual enrolls in Medicare. If such individual
2167 enrolls in Medicare, any such reduction shall be only to the extent such
2168 coverage is provided by Medicare.

2169 Sec. 31. Sections 38a-553 to 38a-555, inclusive, 38a-565, 38a-568 and
2170 38a-570 to 38a-572, inclusive, of the general statutes are repealed.
2171 (*Effective from passage*)

2172 Sec. 32. Section 38a-538 of the 2014 supplement to the general
2173 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	<i>January 1, 2015</i>	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	<i>January 1, 2015</i>	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>	38a-543
Sec. 31	<i>from passage</i>	Repealer section
Sec. 32	<i>from passage</i>	Repealer section

Statement of Legislative Commissioners:

In subsections (c), (f) and (i) of section 3, references to sections 38a-556 to 38a-559, inclusive, were changed to references to "this section" and sections 38a-556a to 38a-559, inclusive, for accuracy.

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note**State Impact:** None**Municipal Impact:** None**Explanation**

The bill makes various changes to insurance statute to conform to the federal Affordable Care Act, rate filing requirements, private insurance coverage for individuals eligible for Medicare, and changes to the Health Reinsurance Association and Connecticut Small Employer Health Reinsurance Pool. These provisions are not anticipated to result in a fiscal impact to the state or municipalities.

The Out Years**State Impact:** None**Municipal Impact:** None

OLR Bill Analysis**sSB 478****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 CERTAIN GROUP HEALTH INSURANCE POLICIES.****SUMMARY:**

This bill requires health insurance companies to file small employer group health insurance premium rates with the insurance commissioner and prohibits them from issuing or delivering policies or certificates in Connecticut to small employers (those with up to 50 employees) unless the commissioner approves the rates (§ 29). By law, the commissioner must review and approve rates for (1) individual insurance policies and HMO plans and (2) small group HMO plans.

The bill prohibits group health insurance policies, regardless of the employer's size, from reducing a person's coverage under a policy because he or she is eligible for Medicare for any reason (e.g., age, disability, or end stage renal disease) (§ 30). It allows a coverage reduction for Medicare enrollees but only to the extent Medicare provides coverage. Current law prohibits policies issued to employers with (1) fewer than 20 employees from reducing coverage when a person is eligible for Medicare because of turning age 65 and (2) 20 or more employees from discriminating against a person in terms of benefits because he or she turned age 65.

The bill also makes numerous revisions in the insurance statutes to conform to the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). The bill:

1. broadens the prohibition on insurers using preexisting condition provisions, which limit or exclude benefits because a person had

- a health condition before coverage was effective (§ 28);
2. prohibits insurers from using gender, industry, and group size as rating factors for small employer group health insurance policies (§§ 5 & 7);
 3. allows insurers to include tobacco use, provider networks, and administrative expenses as rating factors for small employer health insurance policies (§ 8);
 4. requires health insurance plans to provide a special enrollment period for eligible employees and dependents, similar to current law for late enrollees (§ 7);
 5. requires insurers to make small employer health insurance policies available on a guaranteed issue basis (i.e., the insurer must accept every applicant) (§ 7);
 6. eliminates a requirement that insurers offer people covered under a group policy a right to convert to individual coverage upon termination of group coverage (i.e., conversion privilege), which is no longer necessary because of guaranteed issue requirements (§§ 11 & 12); and
 7. eliminates requirements that insurers, the Health Reinsurance Association (HRA), and Connecticut Small Employer Health Reinsurance Pool (CSEHRP) offer certain statutory benefit plans (§§ 1-3, 9-10, 31, & 32).

Lastly, the bill eliminates obsolete provisions and makes technical and conforming changes (§§ 4 & 13-27).

EFFECTIVE DATE: Upon passage, except for a technical change and a provision that allows insurers to include tobacco use, provider networks, and administrative expenses as rating factors for small employer health insurance policies, which are effective January 1, 2015.

§ 28 — PRE-EXISTING CONDITION PROVISIONS

The bill prohibits individual and group health insurance plans or arrangements issued by insurers, HMOs, fraternal benefit societies, and hospital or medical service corporations from including preexisting condition provisions for covered adults. Current law already (1) prohibits preexisting condition provisions for children under age 19 and (2) generally bans the imposition of such provisions that extend beyond the first 12 months of coverage.

A “preexisting condition provision” is a policy provision limiting or excluding coverage for a condition that existed before the coverage effective date for which any medical advice, diagnosis, care, or treatment was recommended or received before the effective date.

§§ 5, 7, & 8 — SMALL EMPLOYER RATING FACTORS

The bill distinguishes between grandfathered and non-grandfathered plans with regards to permissible rating factors for small employer health insurance policies.

A “grandfathered plan” is a health insurance plan that was in existence on March 23, 2010 and has not been changed in ways that substantially reduce benefits or increase costs for consumers.

Grandfathered Plans

The bill retains current law with respect to grandfathered plans. Thus, it allows insurers to charge rates for grandfathered small employer plans that vary by age, gender, geographic area, industry, group size, and administrative cost savings for certain associations.

Non-Grandfathered Plans

For non-grandfathered plans, the bill eliminates gender, industry, group size, and administrative cost savings as rating factors.

Effective upon passage, the bill allows rates for non-grandfathered small employer plans to vary based only on (1) age, according to a uniform age rating curve the commissioner establishes, and (2) geographic area, as the commissioner defines. Effective January 1, 2015, it also allows the rates to vary based on tobacco use, but such a

rate may not vary by a ratio of more than 1.5 to 1.0 and may only be applied with respect to people who can legally use tobacco. "Tobacco use" means using tobacco four or more times a week on average within the preceding six-month period.

Effective upon the bill's passage:

1. total premium rates for family coverage under non-grandfathered plans must be determined by adding the premiums for each family member, but for children under age 21, only the premiums for the three oldest covered children will be added;
2. premium rates for a small employer group must be determined by calculating the premium rate for each covered employee and dependent and totaling the premiums attributable to each; and
3. premium rates may vary by plan based on actuarially justified differences in plan design.

Effective January 1, 2015, premium rates for non-grandfathered plans may also vary by actuarially justified amounts to reflect the plan's provider network and administrative expense differences.

§ 7 — SPECIAL ENROLLMENT PERIOD

The bill requires small employer health insurance plans to provide eligible employees and dependents a special enrollment period in accordance with federal regulation. This is similar to current state law regarding late enrollees.

Under federal regulations, a health insurance issuer may restrict enrollment to (1) an open enrollment period when people may purchase health insurance and (2) special enrollment periods when people who experience qualifying life-changing events may purchase health insurance (45 CFR 147.104). Qualifying events include changes in marriage status, dependents, or employment status, among other things. The plans must give a person 30 days from the date of a

qualifying event to elect coverage.

The bill also requires plans to provide a special enrollment period for an eligible employee whom a court has ordered to provide coverage for a spouse or minor child. The employee must request enrollment within 30 days after the court's order.

§§ 1-3, 9-10, 31, & 32 — HEALTH REINSURANCE ASSOCIATION (HRA) AND CONNECTICUT SMALL EMPLOYER HEALTH REINSURANCE POOL (CSEHRP)

HRA is a nonprofit entity whose members include insurers and HMOs doing business in Connecticut. It serves as the state's insurer of last resort. CSEHRP is a reinsurance pool through which member insurers purchase reinsurance coverage for an entire small group or for certain eligible employees or dependents in a group, generally those the insurer believes are high risk (i.e., likely to have high claim costs).

The bill eliminates the requirement that HRA make individual and group comprehensive health care plans available to people unable to obtain insurance coverage through other means. The ACA instead requires insurers to offer plans that cover essential health benefits on a guarantee issue basis. Under current law, individual and group comprehensive health care plans include specified minimum benefits, including coverage for catastrophic illness and a lifetime maximum coverage of \$1 million.

The bill also eliminates the requirement that CSEHRP make special health care plans available to previously uninsured small employers. Current law requires the CSEHRP board of directors to develop these plans as a lower-cost health insurance coverage option for uninsured small employers.

The bill retains HRA and CSEHRP as the entities that will provide reinsurance in the individual and small group markets, respectively. Under the bill, HRA can administer state or federal programs that may be required or permitted, with the insurance commissioner's approval. The bill requires the CSEHRP board of directors to develop a family

health statement, instead of an underwriting plan, for insurers to use to determine whether to cede lives to the reinsurance pool. The insurance commissioner must approve the statement.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/20/2014)