



Senate

General Assembly

File No. 391

January Session, 2015

Substitute Senate Bill No. 1023

Senate, April 2, 2015

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 REVISIONS TO THE HEALTH INSURANCE STATUTES.

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

1 Section 1. Subsection (a) of section 38a-183 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective from*
3 *passage*):

4 (a) (1) A health care center governed by sections 38a-175 to 38a-192,
5 inclusive, shall not enter into any agreement with subscribers unless
6 and until it has filed with the commissioner a full schedule of the
7 amounts to be paid by the subscribers and has obtained the
8 commissioner's approval thereof. Such filing shall include an actuarial
9 memorandum that includes, but is not limited to, pricing assumptions
10 and claims experience, and premium rates and loss ratios from the
11 inception of the contract or policy. The commissioner may refuse such
12 approval if [he] the commissioner finds such amounts to be excessive,
13 inadequate or discriminatory. [Each] As used in this subsection, "loss
14 ratio" means the ratio of incurred claims to earned premiums by the

15 number of years of policy duration for all combined durations.

16 (2) Premium rates offered to individuals shall be consistent with the
17 requirements set forth in section 38a-481, as amended by this act.

18 (3) Premium rates offered to small employers, as defined in section
19 38a-564, as amended by this act, shall be consistent with the
20 requirements set forth in section 38a-567, as amended by this act.

21 (4) No such health care center shall [not] enter into any agreement
22 with subscribers unless and until it has filed with the commissioner a
23 copy of such agreement or agreements, including all riders and
24 endorsements thereon, and until the commissioner's approval thereof
25 has been obtained. The commissioner shall, within a reasonable time
26 after the filing of any request for an approval of the amounts to be
27 paid, any agreement or any form, notify the health care center of
28 [either his] the commissioner's approval or disapproval thereof.

29 Sec. 2. Section 38a-199 of the general statutes is repealed and the
30 following is substituted in lieu thereof (*Effective from passage*):

31 (a) A hospital service corporation is defined as a non-profit-sharing
32 corporation without capital stock organized under the laws of the state
33 for the purpose of establishing, maintaining and operating a plan
34 whereby comprehensive health care, [which shall include] that
35 includes inpatient and outpatient hospital care and home care,
36 provided and billed by an approved general, special or chronic disease
37 hospital, an approved clinic or an approved chronic and convalescent
38 nursing home, and services incidental thereto, may be provided, at the
39 expense of said corporation, to subscribers to such plan under a
40 contract entitling such subscribers to the benefits provided therein.
41 When so determined by any such corporation comprehensive health
42 care shall also include appliances, drugs, medicines, supplies and all
43 other health goods and services, including the services of physicians,
44 doctors of dentistry and other licensed practitioners of the healing arts.
45 Each such corporation shall be governed by sections 38a-199 to 38a-
46 209, inclusive, and shall, except as [specifically designated herein]

47 otherwise provided in this title, be exempt from the provisions of the
48 general statutes relating to insurance. The provisions of sections 38a-
49 815 to 38a-819, inclusive, except subdivision (9) of section 38a-816,
50 shall be applicable to such corporation. Such hospitals, clinics and
51 chronic and convalescent nursing homes as shall be contained in a list
52 of approved institutions maintained by the Department of Public
53 Health shall be deemed approved for the purposes of sections 38a-199
54 to 38a-209, inclusive.

55 (b) A hospital service corporation providing health care benefits to
56 plan subscribers under the provisions of subsection (a) of this section
57 may, upon obtaining the approval of the Insurance Commissioner as
58 provided in section 38a-208, as amended by this act: (1) [Adjust the
59 rates to be paid by any group or groups of its subscribers based upon
60 past and prospective loss experience and may classify subscribers and
61 groups of subscribers and determine rates with reference to standards
62 for variations or risks or expenses which it may establish; (2) contract]
63 Contract for the coordination of benefits with other hospital service
64 corporations, medical service corporations or insurance companies to
65 avoid duplication of benefits to be provided to its group subscribers;
66 [(3)] (2) make loans, grants or provide anything of value to a health
67 care center covering all or part of the cost of health services provided
68 to members; [(4)] (3) contract with a health care center to provide
69 insurance or similar protection to cover the cost of care provided
70 through health care centers and to provide coverage in the event of the
71 insolvency of the health care center; and [(5)] (4) establish, maintain,
72 own and operate health care centers as a line of business, provided that
73 (A) aggregate investments hereafter made by such corporation shall
74 not exceed ten per cent of such corporation's contingency reserve as of
75 the date of the investment; (B) such investments shall not be repaid or
76 recovered from rates charged by such corporation for its non-health-
77 care-center lines of business; and (C) the commissioner [shall find]
78 finds, based upon evidence furnished by such corporation, that the
79 financial condition of such corporation and the rates of its non-health-
80 care-center subscribers are not unduly jeopardized by such
81 investment. [Subdivisions (1) and (2)] Subdivision (1) of this subsection

82 shall be subject to such regulations as may be adopted by the
83 Insurance Commissioner, in accordance with the provisions of chapter
84 54, to establish [guidelines of eligibility for experience rating and
85 adoption of] coordination of benefits clauses in health care contracts.

86 (c) Each hospital service corporation shall maintain reserves equal in
87 amount to its liabilities under all its policy contracts, as the same are
88 computed in accordance with regulations [of the commissioner]
89 adopted in accordance with chapter 54 upon reasonable consideration
90 of ascertained experience for the purpose of adequately protecting the
91 subscriber and securing the solvency of such company. Each such
92 corporation shall maintain a reserve for contingencies [which] that
93 shall not be less than the amount required by companies licensed to
94 transact accident and health insurance, under section 38a-72. The
95 commissioner may adopt regulations, in accordance with the
96 provisions of chapter 54, prescribing the maximum amount that may
97 be held in the reserve for contingencies, and in adopting such
98 regulations, [he] shall consider the stability, solvency and interests of
99 the corporation and the interests of the subscribers and other affected
100 persons. [The commissioner shall allow a reasonable period of time for
101 compliance with this section, not to exceed five years.] On and after
102 October 1, 1974, the commissioner may require a hospital service
103 corporation to adjust its reserve for contingencies to comply with the
104 provisions of this section and to adjust its rates or benefits or both to
105 reflect the adjustment in the reserve for contingencies.

106 Sec. 3. Section 38a-208 of the general statutes is repealed and the
107 following is substituted in lieu thereof (*Effective from passage*):

108 (a) No such corporation shall enter into any contract with
109 subscribers unless and until it has filed with the Insurance
110 Commissioner a full schedule of the rates to be paid by the subscribers
111 and has obtained said commissioner's approval thereof. Such filing
112 shall include an actuarial memorandum that includes, but is not
113 limited to, pricing assumptions and claims experience, and premium
114 rates and loss ratios from the inception of the contract. The

115 commissioner may refuse such approval if [he] the commissioner finds
116 such rates to be excessive, inadequate or discriminatory. As used in
117 this subsection, "loss ratio" means the ratio of incurred claims to
118 earned premiums by the number of years of policy duration for all
119 combined durations.

120 (b) Premium rates offered to individuals shall be consistent with the
121 requirements set forth in section 38a-481, as amended by this act.

122 (c) Premium rates offered to small employers, as defined in section
123 38a-564, as amended by this act, shall be consistent with the
124 requirements set forth in section 38a-567, as amended by this act.

125 (d) No hospital service corporation shall enter into any contract with
126 subscribers unless and until it has filed with the Insurance
127 Commissioner a copy of such contract, including all riders and
128 endorsements thereof, and until said commissioner's approval thereof
129 has been obtained. The Insurance Commissioner shall, within a
130 reasonable time after the filing of any such form, notify such
131 corporation [either of his] of the commissioner's approval or
132 disapproval thereof.

133 Sec. 4. Section 38a-214 of the general statutes is repealed and the
134 following is substituted in lieu thereof (*Effective from passage*):

135 (a) A nonprofit medical service corporation is defined as a non-
136 profit-sharing corporation without capital stock organized under the
137 laws of the state for the purpose of establishing, maintaining and
138 operating a plan whereby comprehensive health care, [which shall
139 include] that includes inpatient and outpatient hospital care and home
140 care, provided and billed by an approved general, special or chronic
141 disease hospital, an approved clinic or an approved chronic and
142 convalescent nursing home and services incidental thereto may be
143 provided, at the expense of said corporation, to subscribers to such
144 plan under a contract entitling such subscribers to the benefits
145 provided therein. When so determined by any such corporation,
146 comprehensive health care shall also include appliances, drugs,

147 medicines, supplies and all other health goods and services, including
148 the services of physicians, doctors of dentistry and other licensed
149 practitioners of the healing arts. Any such corporation [which] that
150 provides coverage for the services of physicians shall also provide
151 coverage for the services of chiropractors licensed under chapter 372
152 and naturopaths licensed under chapter 373. Each such corporation
153 shall, except as [specifically designated herein] otherwise provided in
154 this title, be exempt from the provisions of the general statutes relating
155 to insurance. The provisions of sections 38a-815 to 38a-819, inclusive,
156 except subdivision (9) of section 38a-816, shall be applicable to such
157 corporation. Such hospitals, clinics and chronic and convalescent
158 nursing homes as shall be contained in a list of approved institutions
159 maintained by the Department of Public Health shall be deemed
160 approved for the purposes of sections 38a-214 to 38a-225, inclusive.

161 (b) A medical service corporation providing health care benefits to
162 plan subscribers under the provisions of subsection (a) of this section
163 may, upon obtaining the approval of the Insurance Commissioner as
164 provided in section 38a-218, as amended by this act: (1) [Adjust the
165 rates to be paid by any group or groups of its subscribers based upon
166 past and prospective loss experience and may classify subscribers and
167 groups of subscribers and determine rates with reference to standards
168 for variations of risks or expenses which it may establish; (2) contract]
169 Contract for the coordination of benefits with other hospital service
170 corporations, medical service corporations or insurance companies to
171 avoid duplication of benefits to be provided to its group subscribers;
172 [(3)] (2) make loans, grants or provide anything of value to a health
173 care center covering all or part of the cost of health services provided
174 to members; [(4)] (3) contract with a health care center to provide
175 insurance or similar protection to cover the cost of care provided
176 through health care centers and to provide coverage in the event of the
177 insolvency of the health care center; and [(5)] (4) establish, maintain,
178 own and operate health care centers as a line of business, provided that
179 (A) aggregate investments hereafter made by such corporation shall
180 not exceed ten per cent of such corporation's contingency reserve as of
181 the date of the investment; (B) such investments shall not be repaid or

182 recovered from rates charged by such corporation for its non-health-
183 care-center lines of business; and (C) the commissioner [shall find]
184 finds, based upon evidence furnished by such corporation, that the
185 financial condition of such corporation and the rates of its non-health-
186 care-center subscribers are not unduly jeopardized by such
187 investment. [Subdivisions] Subdivision (1) [and (2)] of this subsection
188 shall be subject to such regulations as may be adopted by the
189 Insurance Commissioner, in accordance with the provisions of chapter
190 54, to establish [guidelines of eligibility for experience rating and
191 adoption of] coordination of benefits clauses in health care benefit
192 contracts.

193 (c) Each medical service corporation shall maintain reserves equal in
194 amount to its liabilities under all its policy contracts, as the same are
195 computed in accordance with regulations [of the commissioner]
196 adopted in accordance with chapter 54 upon reasonable consideration
197 of ascertained experience for the purpose of adequately protecting the
198 subscriber or securing the solvency of such company. Each such
199 corporation shall maintain a reserve for contingencies [which] that
200 shall not be less than the amount required by companies licensed to
201 transact accident and health insurance, under section 38a-72. The
202 commissioner may adopt regulations, in accordance with the
203 provisions of chapter 54, prescribing the maximum amount that may
204 be held in the reserve for contingencies, and in adopting such
205 regulations, [he] shall consider the stability, solvency and interests of
206 the corporation, and the interests of the subscribers and other affected
207 persons. [The commissioner shall allow a reasonable period of time for
208 compliance with this section, not to exceed five years.] On and after
209 October 1, 1974, the commissioner may require a medical service
210 corporation to adjust its reserve for contingencies to comply with the
211 provisions of this section and to adjust its rates or benefits or both to
212 reflect such adjustment in the reserve for contingencies.

213 Sec. 5. Section 38a-218 of the general statutes is repealed and the
214 following is substituted in lieu thereof (*Effective from passage*):

215 (a) No such medical service corporation shall enter into any contract
216 with subscribers unless and until it has filed with the Insurance
217 Commissioner a full schedule of the rates to be paid by the subscriber
218 and has obtained said commissioner's approval thereof. Such filing
219 shall include an actuarial memorandum that includes, but is not
220 limited to, pricing assumptions and claims experience, and premium
221 rates and loss ratios from the inception of the contract. The
222 commissioner may refuse such approval if [he] the commissioner finds
223 such rates are excessive, inadequate or discriminatory. As used in this
224 subsection, "loss ratio" means the ratio of incurred claims to earned
225 premiums by the number of years of policy duration for all combined
226 durations.

227 (b) Premium rates offered to individuals shall be consistent with the
228 requirements set forth in section 38a-481, as amended by this act.

229 (c) Premium rates offered to small employers, as defined in section
230 38a-564, as amended by this act, shall be consistent with the
231 requirements set forth in section 38a-567, as amended by this act.

232 (d) No such medical service corporation shall enter into any contract
233 with subscribers unless and until it has filed with the Insurance
234 Commissioner a copy of such contract, including all riders and
235 endorsements thereof, and until said commissioner's approval thereof
236 has been obtained. The Insurance Commissioner shall, within a
237 reasonable time after the filing of any such form, notify such
238 corporation [either of his] of the commissioner's approval or
239 disapproval thereof.

240 Sec. 6. Section 38a-481 of the general statutes is repealed and the
241 following is substituted in lieu thereof (*Effective from passage*):

242 (a) No individual health insurance policy shall be delivered or
243 issued for delivery to any person in this state, nor shall any
244 application, rider or endorsement be used in connection with such
245 policy, until a copy of the form thereof and of the classification of risks
246 and the premium rates have been filed with the commissioner. Rate

247 filings shall include an actuarial memorandum that includes, but is not
248 limited to, pricing assumptions and claims experience, and premium
249 rates and loss ratios from the inception of the policy. The
250 commissioner shall adopt regulations, in accordance with the
251 provisions of chapter 54, to establish a procedure for reviewing such
252 policies. The commissioner shall disapprove the use of such form at
253 any time if it does not comply with the requirements of law, or if it
254 contains a provision or provisions [which] that are unfair or deceptive
255 or [which] that encourage misrepresentation of the policy. The
256 commissioner shall notify, in writing, the insurer [which] that has filed
257 any such form of the commissioner's disapproval, specifying the
258 reasons for disapproval, and ordering that no such insurer shall
259 deliver or issue for delivery to any person in this state a policy on or
260 containing such form. The provisions of section 38a-19 shall apply to
261 such orders. As used in this subsection, "loss ratio" means the ratio of
262 incurred claims to earned premiums by the number of years of policy
263 duration for all combined durations.

264 (b) No rate filed under the provisions of subsection (a) of this
265 section shall be effective until it has been [filed and] approved by the
266 commissioner in accordance with regulations adopted pursuant to this
267 subsection. The commissioner shall adopt regulations, in accordance
268 with the provisions of chapter 54, to prescribe standards to ensure that
269 such rates shall not be excessive, inadequate or unfairly
270 discriminatory. The commissioner may disapprove such rate [within
271 thirty days after it has been filed] if it fails to comply with such
272 standards, except that no rate filed under the provisions of subsection
273 (a) of this section for any Medicare supplement policy shall be effective
274 unless approved in accordance with section 38a-474.

275 (c) No insurance company, fraternal benefit society, hospital service
276 corporation, medical service corporation, health care center or other
277 entity [which] that delivers or issues for delivery in this state any
278 Medicare supplement policies or certificates shall incorporate in its
279 rates or determinations to grant coverage for Medicare supplement
280 insurance policies or certificates any factors or values based on the age,

281 gender, previous claims history or the medical condition of any person
282 covered by such policy or certificate.

283 (d) [For the purposes of this section, "loss ratio" means the ratio of
284 incurred claims to earned premiums by the number of years of policy
285 duration for all combined durations.] No individual health insurance
286 policy delivered, issued for delivery, renewed, amended or continued
287 in this state shall include any provision that reduces payments on the
288 basis that an individual is eligible for Medicare by reason of age,
289 disability or end-stage renal disease, unless such individual enrolls in
290 Medicare. If such individual enrolls in Medicare, any such reduction
291 shall be only to the extent such coverage is provided by Medicare.

292 (e) Nothing in this chapter shall preclude the issuance of an
293 individual health insurance policy that includes an optional life
294 insurance rider, provided the optional life insurance rider shall be filed
295 with and approved by the Insurance Commissioner pursuant to
296 section 38a-430. Any company offering such policies for sale in this
297 state shall be licensed to sell life insurance in this state pursuant to the
298 provisions of section 38a-41.

299 [(f) No insurance company, fraternal benefit society, hospital service
300 corporation, medical service corporation, health care center or other
301 entity that delivers, issues for delivery, amends, renews or continues
302 an individual health insurance policy in this state shall: (1) Move an
303 insured individual from a standard underwriting classification to a
304 substandard underwriting classification after the policy is issued; (2)
305 increase premium rates due to the claim experience or health status of
306 an individual who is insured under the policy, except that the entity
307 may increase premium rates for all individuals in an underwriting
308 classification due to the claim experience or health status of the
309 underwriting classification as a whole; or (3) use an individual's
310 history of taking a prescription drug for anxiety for six months or less
311 as a factor in its underwriting unless such history arises directly from a
312 medical diagnosis of an underlying condition.]

313 (f) Health insurance issued to an association or other insurance

314 arrangement that is not made up solely of employer groups shall be
315 treated as individual health insurance.

316 (g) (1) As used in this subsection, "Affordable Care Act" means the
317 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
318 from time to time, and regulations adopted thereunder, and
319 "grandfathered plan" has the same meaning as "grandfathered health
320 plan" as provided in the Affordable Care Act.

321 (2) Each individual health insurance policy subject to the Affordable
322 Care Act shall be offered on a guaranteed issue basis with respect to all
323 eligible individuals or dependents.

324 (3) With respect to grandfathered plans of a policy under
325 subdivision (2) of this subsection, the premium rates charged or
326 offered shall be established on the basis of a single pool of all
327 grandfathered plans.

328 (4) With respect to nongrandfathered plans of a policy under
329 subdivision (2) of this subsection:

330 (A) The premium rates charged or offered shall be established on
331 the basis of a single pool of all nongrandfathered plans, adjusted to
332 reflect one or more of the following classifications:

333 (i) Age, in accordance with a uniform age rating curve established
334 by the commissioner;

335 (ii) Geographic area, as defined by the commissioner;

336 (iii) Tobacco use, except that such rate may not vary by a ratio of
337 greater than 1.5 to 1.0 and may only be applied with respect to
338 individuals who may legally use tobacco under state and federal law.
339 For purposes of this subparagraph, "tobacco use" means the use of
340 tobacco products four or more times per week on average within a
341 period not longer than the six months immediately preceding.
342 "Tobacco use" does not include the religious or ceremonial use of
343 tobacco;

344 (B) Total premium rates for family coverage shall be determined by
345 adding the premiums for each individual family member, except that
346 with respect to family members under twenty-one years of age, the
347 premiums for only the three oldest covered children shall be taken into
348 account in determining the total premium rate for such family.

349 (5) Premium rates for a grandfathered or nongrandfathered policy
350 under subdivision (2) of this subsection may vary by (A) actuarially
351 justified differences in plan design, and (B) actuarially justified
352 amounts to reflect the policy's provider network and administrative
353 expense differences that can be reasonably allocated to such policy.

354 Sec. 7. Subsections (a) and (b) of section 38a-513 of the general
355 statutes are repealed and the following is substituted in lieu thereof
356 (*Effective from passage*):

357 (a) (1) No group health insurance policy, as defined by the
358 commissioner, or certificate shall be [issued or] delivered or issued for
359 delivery in this state unless a copy of the form for such policy or
360 certificate has been submitted to and approved by the commissioner
361 under the regulations adopted pursuant to this section. The
362 commissioner shall adopt regulations, in accordance with the
363 provisions of chapter 54, concerning the provisions, submission and
364 approval of such policies and certificates and establishing a procedure
365 for reviewing such policies and certificates. [If the commissioner issues
366 an order disapproving the use of such form, the] The commissioner
367 shall disapprove the use of such form at any time if it does not comply
368 with the requirements of law, or if it contains a provision or provisions
369 that are unfair or deceptive or that encourage misrepresentation of the
370 policy. The commissioner shall notify, in writing, the insurer that has
371 filed any such form of the commissioner's disapproval, specifying the
372 reasons for disapproval, and ordering that no such insurer shall
373 deliver or issue for delivery to any person in this state a policy on or
374 containing such form. The provisions of section 38a-19 shall apply to
375 such order.

376 (2) No group health insurance policy or certificate for a small

377 employer, as defined in section 38a-564, as amended by this act, shall
378 be delivered or issued for delivery in this state unless the premium
379 rates have been submitted to and approved by the commissioner.
380 Premium rate filings shall include an actuarial memorandum that
381 includes, but is not limited to, pricing assumptions and claims
382 experience, and premium rates and loss ratios from the inception of
383 the policy. As used in this subdivision, "loss ratio" means the ratio of
384 incurred claims to earned premiums by the number of years of policy
385 duration for all combined durations.

386 (b) No insurance company, fraternal benefit society, hospital service
387 corporation, medical service corporation, health care center or other
388 entity [which] that delivers or issues for delivery in this state any
389 Medicare supplement policies or certificates shall incorporate in its
390 rates or determinations to grant coverage for Medicare supplement
391 insurance policies or certificates any factors or values based on the age,
392 gender, previous claims history or the medical condition of any person
393 covered by such policy or certificate.

394 Sec. 8. Section 38a-476 of the general statutes is repealed and the
395 following is substituted in lieu thereof (*Effective from passage*):

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

397 (1) "Health insurance plan" means any hospital and medical expense
398 incurred policy, hospital or medical service plan contract and health
399 care center subscriber contract. [and] "Health insurance plan" does not
400 include (A) short-term health insurance issued on a nonrenewable
401 basis with a duration of six months or less, accident only, credit,
402 dental, vision, Medicare supplement, long-term care or disability
403 insurance, hospital indemnity coverage, coverage issued as a
404 supplement to liability insurance, insurance arising out of a workers'
405 compensation or similar law, automobile medical payments insurance,
406 or insurance under which beneficiaries are payable without regard to
407 fault and which is statutorily required to be contained in any liability
408 insurance policy or equivalent self-insurance, or (B) policies of
409 specified disease or limited benefit health insurance, provided that the

410 carrier offering such policies files on or before March first of each year
411 a certification with the Insurance Commissioner that contains the
412 following: (i) A statement from the carrier certifying that such policies
413 are being offered and marketed as supplemental health insurance and
414 not as a substitute for hospital or medical expense insurance; (ii) a
415 summary description of each such policy including the average annual
416 premium rates, or range of premium rates in cases where premiums
417 vary by age, gender or other factors, charged for such policies in the
418 state; and (iii) in the case of a policy that is described in this
419 subparagraph and that is offered for the first time in this state on or
420 after October 1, 1993, the carrier files with the commissioner the
421 information and statement required in this subparagraph at least thirty
422 days prior to the date such policy is issued or delivered in this state.

423 (2) "Insurance arrangement" means any "multiple employer welfare
424 arrangement", as defined in Section 3 of the Employee Retirement
425 Income Security Act of 1974, as amended from time to time, except for
426 any such arrangement [which] that is fully insured within the meaning
427 of Section 514(b)(6) of said act, as amended from time to time.

428 (3) "Preexisting conditions provision" means a policy provision
429 [which] that limits or excludes benefits relating to a condition based on
430 the fact that the condition was present before the effective date of
431 coverage, for which any medical advice, diagnosis, care or treatment
432 was recommended or received before such effective date. Routine
433 follow-up care to determine whether a breast cancer has reoccurred in
434 a person who has been previously determined to be breast cancer free
435 shall not be considered as medical advice, diagnosis, care or treatment
436 for purposes of this section unless evidence of breast cancer is found
437 during or as a result of such follow-up. Genetic information shall not
438 be treated as a condition in the absence of a diagnosis of the condition
439 related to such information. Pregnancy shall not be considered a
440 preexisting condition.

441 [(4) "Qualifying coverage" means (A) any group health insurance
442 plan, insurance arrangement or self-insured plan, (B) Medicare or

443 Medicaid, or (C) an individual health insurance plan that provides
444 benefits which are actuarially equivalent to or exceeding the benefits
445 provided under the small employer health care plan, as defined in
446 subdivision (12) of section 38a-564, whether issued in this state or any
447 other state.]

448 [(5)] (4) "Applicable waiting period" means the period of time
449 imposed by the group policyholder or contractholder before an
450 individual is eligible for participating in the group policy or contract.

451 (b) (1) No group health insurance plan or insurance arrangement
452 shall impose a preexisting conditions provision [that excludes
453 coverage for (A) individuals eighteen years of age and younger, or (B)
454 a period beyond twelve months following the insured's effective date
455 of coverage. Any preexisting conditions provision shall only relate to
456 conditions, whether physical or mental, for which medical advice,
457 diagnosis or care or treatment was recommended or received during
458 the six months immediately preceding the effective date of coverage]
459 on any individual.

460 (2) No individual health insurance plan or insurance arrangement
461 shall impose a preexisting conditions provision [that excludes
462 coverage for (A) individuals eighteen years of age and younger, or (B)
463 a period beyond twelve months following the insured's effective date
464 of coverage. Any preexisting conditions provision shall only relate to
465 conditions, whether physical or mental, for which medical advice,
466 diagnosis or care or treatment was recommended or received during
467 the twelve months immediately preceding the effective date of
468 coverage] on any individual.

469 (3) No insurance company, fraternal benefit society, hospital service
470 corporation, medical service corporation or health care center shall
471 refuse to issue an individual health insurance plan or insurance
472 arrangement to [individuals eighteen years of age and younger] any
473 individual solely on the basis that [an] such individual has a
474 preexisting condition.

475 [(c) All health insurance plans and insurance arrangements shall
476 provide coverage, under the terms and conditions of their policies or
477 contracts, for the preexisting conditions of any newly insured
478 individual who was previously covered for such preexisting condition
479 under the terms of the individual's preceding qualifying coverage,
480 provided the preceding coverage was continuous to a date less than
481 one hundred twenty days prior to the effective date of the new
482 coverage, exclusive of any applicable waiting period, except in the case
483 of a newly insured group member whose previous coverage was
484 terminated due to an involuntary loss of employment, the preceding
485 coverage must have been continuous to a date not more than one
486 hundred fifty days prior to the effective date of the new coverage,
487 exclusive of any applicable waiting period, provided such newly
488 insured group member or dependent applies for such succeeding
489 coverage within thirty days of the member's or dependent's initial
490 eligibility.

491 (d) With respect to a newly insured individual who was previously
492 covered under qualifying coverage, but who was not covered under
493 such qualifying coverage for a preexisting condition, as defined under
494 the new health insurance plan or arrangement, such plan or
495 arrangement shall credit the time such individual was previously
496 covered by qualifying coverage to the exclusion period of the
497 preexisting condition provision, provided the preceding coverage was
498 continuous to a date less than one hundred twenty days prior to the
499 effective date of the new coverage, exclusive of any applicable waiting
500 period under such plan, except in the case of a newly insured group
501 member whose preceding coverage was terminated due to an
502 involuntary loss of employment, the preceding coverage must have
503 been continuous to a date not more than one hundred fifty days prior
504 to the effective date of the new coverage, exclusive of any applicable
505 waiting period, provided such newly insured group member or
506 dependent applies for such succeeding coverage within thirty days of
507 the member's or dependent's initial eligibility.

508 (e) Each insurance company, fraternal benefit society, hospital

509 service corporation, medical service corporation or health care center
510 which issues in this state group health insurance subject to Section
511 2701 of the Public Health Service Act, as set forth in the Health
512 Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
513 (HIPAA), as amended from time to time, shall comply with the
514 provisions of said section with respect to such group health insurance,
515 except that the longer period of days specified in subsections (c) and
516 (d) of this section shall apply to the extent excepted from preemption
517 in Section 2723(B)(2)(iii) of said Public Health Service Act.

518 (f) The provisions of this section shall apply to every health
519 insurance plan or insurance arrangement issued, renewed or
520 continued in this state on or after October 1, 1993. For purposes of this
521 section, the date a plan or arrangement is continued shall be the
522 anniversary date of the issuance of the plan or arrangement. The
523 provisions of subsection (e) of this section shall apply on and after the
524 dates specified in Sections 2747 and 2792 of the Public Health Service
525 Act as set forth in HIPAA.]

526 [(g)] (c) (1) Notwithstanding the provisions of subsection (a) of this
527 section, a short-term health insurance policy issued on a nonrenewable
528 basis for six months or less [which] that imposes a preexisting
529 conditions provision shall be subject to the following conditions: [(1)]
530 (A) No such preexisting conditions provision shall exclude coverage
531 beyond twelve months following the insured's effective date of
532 coverage; [(2)] (B) such preexisting conditions provision may only
533 relate to conditions, whether physical or mental, for which medical
534 advice, diagnosis, care or treatment was recommended or received
535 during the twenty-four months immediately preceding the effective
536 date of coverage; and [(3)] (C) any policy, application or sales brochure
537 issued for such short-term health insurance policy that imposes such
538 preexisting conditions provision shall disclose in a conspicuous
539 manner in not less than fourteen-point bold face type the following
540 statement:

541 "THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR

542 WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT
543 WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-
544 FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE
545 DATE OF COVERAGE."

546 (2) In the event an insurer or health care center issues two
547 consecutive short-term health insurance policies on a nonrenewable
548 basis for six months or less [which imposes] that impose a preexisting
549 conditions provision to the same individual, the insurer or health care
550 center shall reduce the preexisting conditions exclusion period in the
551 second policy by the period of time such individual was covered under
552 the first policy. If the same insurer or health care center issues a third
553 or subsequent such short-term health insurance policy to the same
554 individual, such insurer or health care center shall reduce the
555 preexisting conditions exclusion period in the third or subsequent
556 policy by the cumulative time covered under the prior policies.
557 Nothing in this section shall be construed to require such short-term
558 health insurance policy to be issued on a guaranteed issue or
559 guaranteed renewable basis.

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

563 Sec. 9. Subsection (a) of section 38a-478g of the general statutes is
564 repealed and the following is substituted in lieu thereof (*Effective from*
565 *passage*):

566 (a) Each managed care contract delivered, issued for delivery,
567 renewed, amended or continued in this state shall be in writing and a
568 copy thereof furnished to the group contract holder or individual
569 contract holder, as appropriate. Each such contract shall contain the
570 following provisions: (1) Name and address of the managed care
571 organization; (2) eligibility requirements; (3) a statement of
572 copayments, deductibles or other out-of-pocket expenses the enrollee
573 must pay; (4) a statement of the nature of the health care services,
574 benefits or coverages to be furnished and the period during which they

575 will be furnished and, if there are any services, benefits or coverages to
576 be excepted, a detailed statement of such exceptions; (5) a statement of
577 terms and conditions upon which the contract may be cancelled or
578 otherwise terminated at the option of either party; (6) claims
579 procedures; (7) enrollee grievance procedures; (8) continuation of
580 coverage; (9) [conversion; (10)] extension of benefits, if any; [(11)] (10)
581 subrogation, if any; [(12)] (11) description of the service area, and out-
582 of-area benefits and services, if any; [(13)] (12) a statement of the
583 amount the enrollee or others on his behalf must pay to the managed
584 care organization and the manner in which such amount is payable;
585 [(14)] (13) a statement that the contract includes the endorsement
586 thereon and attached papers, if any, and contains the entire contract;
587 [(15)] (14) a statement that no statement by the enrollee in his
588 application for a contract shall void the contract or be used in any legal
589 proceeding thereunder, unless such application or an exact copy
590 thereof is included in or attached to such contract; and [(16)] (15) a
591 statement of the grace period for making any payment due under the
592 contract, which shall not be less than ten days. The commissioner may
593 waive the requirements of this subsection for any managed care
594 organization subject to the provisions of section 38a-182.

595 Sec. 10. Section 38a-505 of the general statutes is repealed and the
596 following is substituted in lieu thereof (*Effective from passage*):

597 In order to provide reasonable simplification of terms and coverages
598 of individual health insurance policies, to facilitate public
599 understanding and comparison, to eliminate provisions [which] that
600 may be misleading or unreasonably confusing in connection with
601 either the purchase of such coverage or with the settlement of claims
602 and to provide for full disclosure in the sale of such coverages:

603 [(a)] (1) The commissioner shall [issue] adopt regulations, in
604 accordance with the provisions of chapter 54, to establish specific
605 standards for policy provisions used in individual health insurance
606 policies, [but not including group conversion policies, which] that shall
607 be in addition to and in accordance with sections 38a-80, 38a-321 to

608 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
609 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
610 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
611 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, and other
612 applicable laws of this state [which] that may cover the terms of
613 renewability, initial and subsequent conditions of eligibility,
614 nonduplication of coverage provisions, coverage of dependents,
615 termination of insurance, probationary periods, limitations, exceptions,
616 reductions, elimination periods, requirements for replacements,
617 recurrent conditions, preexisting conditions, and the definition of the
618 terms hospital, accident, sickness, injury, physician, accidental means,
619 total disability, permanent disability, partial disability, nervous
620 disorders, guaranteed renewable [,] and noncancellable.

621 [(b)] (2) The commissioner shall adopt regulations, in accordance
622 with chapter 54, that specify prohibited policy provisions not
623 otherwise specifically authorized by statute [which] that in the opinion
624 of the commissioner are unjust, unfair or unfairly discriminatory to the
625 policyholder, any person insured under the policy [,] or any
626 beneficiary.

627 [(c)] (3) The commissioner shall adopt regulations, in accordance
628 with chapter 54, to establish minimum standards for benefits under
629 each of the following categories of coverage in individual policies: [,
630 other than conversion policies issued pursuant to a contractual
631 conversion privilege under a group policy:] Basic hospital expense
632 coverage, basic medical-surgical expense coverage, hospital
633 confinement indemnity coverage, major medical expense coverage,
634 disability income protection coverage, accident only coverage,
635 specified accident coverage and specified disease coverage.

636 [(d)] (4) Nothing in this section shall preclude the issuance of any
637 policy [which] that combines two or more of the categories of coverage
638 enumerated in [subsection (c)] subdivision (3) of this section, except
639 that specified accident coverage shall not be combined with any other
640 category of coverage. The commissioner shall prescribe the method of

641 identification of policies based upon coverage provided.

642 [(e)] (5) No policy shall be delivered or issued for delivery in this
643 state [which] that does not meet the prescribed minimum standards for
644 the categories of coverage listed in [subsection (c)] subdivision (3) of
645 this section, provided nothing in this section shall preclude the
646 issuance or delivery of any policy [which] that does not meet such
647 prescribed minimum standards of coverage so long as such policy is
648 clearly identified as not meeting such prescribed standards.

649 [(f)] (6) No such policy shall be delivered in this state unless: [(1)]
650 (A) An outline of coverage described herein accompanies the policy or
651 [(2)] (B) the outline of coverage described in this section is delivered to
652 the applicant at the time application is made and acknowledgment of
653 receipt of certificate of delivery of such outline is provided the carrier
654 with the application. In the event the policy is issued on a basis other
655 than that applied for, the outline of coverage properly describing the
656 policy shall accompany the policy when it is delivered. The outline of
657 coverage shall include: [(A)] (i) A statement identifying the applicable
658 category or categories of coverage provided by the policy in
659 accordance with this section; [(B)] (ii) a description of the principal
660 benefits and coverage provided in the policy; [(C)] (iii) a statement of
661 the exceptions, reductions and limitations contained in the policy or
662 contract; [(D)] (iv) a statement of the renewal provisions including any
663 reservation by the carrier of a right to change premiums; and [(E)] (v) a
664 statement that the outline is a summary of the policy issued or applied
665 for and that the policy should be consulted to determine governing
666 contractual provisions.

667 [(g)] Notwithstanding the provisions of sections 38a-80, 38a-321 to
668 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
669 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
670 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
671 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, if a carrier
672 elects to use a simplified application form, with or without any
673 questions as to the applicant's health at the time of application, but

674 without any questions concerning the insured's health history or
675 medical treatment history, the policy shall cover loss developing after
676 twelve months from any preexisting condition not specifically
677 excluded from coverage by the terms of the policy and, except as so
678 provided, the policy shall not include wording that would permit a
679 defense based upon preexisting conditions.]

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

685 Sec. 11. Section 38a-512a of the general statutes is repealed and the
686 following is substituted in lieu thereof (*Effective from passage*):

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

696 (A) Upon layoff, reduction of hours, leave of absence or termination
697 of employment, other than as a result of death of the employee or as a
698 result of such employee's "gross misconduct" as that term is used in 29
699 USC 1163(2), continuation of coverage for such employee and such
700 employee's covered dependents for a period of thirty months after the
701 date of such layoff, reduction of hours, leave of absence or termination
702 of employment, except that if such reduction of hours, leave of absence
703 or termination of employment results from an employee's eligibility to
704 receive Social Security income, continuation of coverage for such
705 employee and such employee's covered dependents until midnight of
706 the day preceding such person's eligibility for benefits under Title

707 XVIII of the Social Security Act;

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

713 (C) Regardless of the employee's or dependent's eligibility for other
714 group insurance, during an employee's absence due to illness or injury,
715 continuation of coverage for such employee and such employee's
716 covered dependents during continuance of such illness or injury or for
717 up to twelve months from the beginning of such absence;

718 (D) Regardless of an individual's eligibility for other group
719 insurance, upon termination of the group policy, coverage for covered
720 individuals who were totally disabled on the date of termination shall
721 be continued without premium payment during the continuance of
722 such disability for a period of twelve calendar months following the
723 calendar month in which such policy was terminated, provided claim
724 is submitted for coverage within one year of the termination of such
725 policy;

726 (E) The coverage of any covered individual shall terminate: (i) As to
727 a child, (I) as set forth in section 38a-512b. If on the date specified for
728 termination of coverage on a child, the child is incapable of self-
729 sustaining employment by reason of mental or physical handicap and
730 chiefly dependent upon the employee for support and maintenance,
731 the coverage on such child shall continue while the plan remains in
732 force and the child remains in such condition, provided proof of such
733 handicap is received by such insurer, center, corporation, society or
734 other entity within thirty-one days of the date on which the child's
735 coverage would have terminated in the absence of such incapacity.
736 Such insurer, center, corporation, society or other entity may require
737 subsequent proof of the child's continued incapacity and dependency
738 but not more often than once a year thereafter, or (II) for the periods
739 set forth for such child under federal extension requirements

740 established by the Consolidated Omnibus Budget Reconciliation Act of
741 1985, P.L. 99-272, as amended from time to time; (ii) as to the
742 employee's spouse, at the end of the month following the month in
743 which a divorce, court-ordered annulment or legal separation is
744 obtained, whichever is earlier, except that the plan shall provide the
745 option for said spouse to continue coverage for the periods set forth for
746 such events under federal extension requirements established by the
747 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
748 as amended from time to time; and (iii) as to the employee or
749 dependent who is sixty-five years of age or older, as of midnight of the
750 day preceding such person's eligibility for benefits under Title XVIII of
751 the federal Social Security Act;

752 (F) As to any other event listed as a "qualifying event" in 29 USC
753 1163, as amended from time to time, continuation of coverage for such
754 periods set forth for such event in 29 USC 1162, as amended from time
755 to time, provided such plan may require the individual whose
756 coverage is to be continued to pay up to the percentage of the
757 applicable premium as specified for such event in 29 USC 1162, as
758 amended from time to time.

759 (2) Any continuation of coverage required by this subsection except
760 subparagraph (D) or (F) of subdivision (1) of this subsection may be
761 subject to the requirement, on the part of the individual whose
762 coverage is to be continued, that such individual contribute that
763 portion of the premium the individual would have been required to
764 contribute had the employee remained an active covered employee,
765 except that the individual may be required to pay up to one hundred
766 two per cent of the entire premium at the group rate if coverage is
767 continued in accordance with subparagraph (A), (B) or (E) of
768 subdivision (1) of this subsection. The employer shall not be legally
769 obligated by section 38a-505, as amended by this act, or 38a-546 to pay
770 such premium if not paid timely by the employee.

771 [(b) The plan shall make available to Connecticut residents, in
772 addition to any other conversion privilege available, a conversion

773 privilege under which coverage shall be available immediately upon
774 termination of coverage under the group policy. The terms and
775 benefits offered under the conversion benefits shall be at least equal to
776 the terms and benefits of an individual health insurance policy.]

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

782 Sec. 12. Section 38a-537 of the general statutes is repealed and the
783 following is substituted in lieu thereof (*Effective from passage*):

784 (a) Any individual, partnership, corporation, or unincorporated
785 association providing group health insurance coverage for its
786 employees shall furnish each insured employee, upon cancellation or
787 discontinuation of such health insurance, notice of the cancellation or
788 discontinuation of such insurance. The notice shall be mailed or
789 delivered to the insured employee not less than fifteen days next
790 preceding the effective date of cancellation or discontinuation. Any
791 individual or any such entity that fails to provide timely notice shall be
792 fined not more than two thousand dollars for each violation. The Labor
793 Commissioner shall have the authority to assess all such fines. This
794 section shall apply to any such individual, partnership, corporation or
795 unincorporated association that substitutes one policy providing
796 group health insurance coverage for another such policy with no
797 interruption in coverage.

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

803 (c) Any individual, partnership, corporation, or unincorporated
804 association which makes deductions from an employee's wages for

805 group health insurance coverage and fails to procure such coverage
806 shall be liable for benefits to the same extent as the insurer, hospital or
807 medical service corporation or health care center would have been
808 liable if coverage had been procured. If any corporation makes
809 deductions from an employee's wages for group health insurance
810 coverage and fails to procure such coverage, any officer of the
811 corporation responsible for procuring such coverage for employees
812 who wilfully failed to procure such coverage shall be personally liable
813 for benefits to the same extent as the insurer, hospital or medical
814 service corporation or health care center would have been liable if
815 coverage had been procured, provided that personal liability shall only
816 be imposed against the officer in the event that an amount owed an
817 employee due to the officer's failure cannot otherwise be collected
818 from the corporation itself.

819 [(d) Whenever an employer ceases doing business, any terminated
820 employee whose group health insurance was discontinued on or
821 before the date of termination of employment and who did not receive
822 notice of such discontinuation pursuant to subsection (a) of this section
823 shall be eligible for ninety days from the date of discontinuation to
824 purchase as a conversion privilege an individual comprehensive health
825 care plan for himself and any dependents covered by the discontinued
826 group health insurance plan from the former insurer, hospital or
827 medical service corporation, health care center or the Health
828 Reinsurance Association, if any insurer is not issuing such coverage,
829 with coverage retroactive to the date of discontinuation. The employee
830 shall pay the premiums for the period of retroactive coverage. No
831 retroactive coverage may be purchased for a period during which the
832 employee is eligible for benefits under another group plan.]

833 Sec. 13. Section 38a-551 of the general statutes is repealed and the
834 following is substituted in lieu thereof (*Effective from passage*):

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

838 [(a)] (1) "Health insurance" or "health care plan" means hospital and
839 medical expenses incurred policies written on a direct basis, nonprofit
840 service plan contracts, health care center contracts and self-insured or
841 self-funded employee health benefit plans. [For purposes of sections
842 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance"]
843 "Health insurance" or "health care plan" does not include [(1)] (A)
844 accident only, credit, dental, vision, Medicare supplement, long-term
845 care or disability insurance, hospital indemnity coverage, coverage
846 issued as a supplement to liability insurance, insurance arising out of a
847 workers' compensation or similar law, automobile medical-payments
848 insurance, or insurance under which beneficiaries are payable without
849 regard to fault and which is statutorily required to be contained in any
850 liability insurance policy or equivalent self-insurance, or [(2)] (B)
851 policies of specified disease or limited benefit health insurance,
852 provided: [(A)] (i) The carrier offering such policies files on or before
853 March first of each year a certification with the commissioner that
854 contains the following: [(i)] (I) A statement from the carrier certifying
855 that such policies are being offered and marketed as supplemental
856 health insurance and not as a substitute for hospital or medical
857 expense insurance; and [(ii)] (II) a summary description of each such
858 policy including the average annual premium rates, or range of
859 premium rates in cases where premiums vary by age, gender or other
860 factors, charged for such policy in the state; and [(B)] (ii) for each such
861 policy that is offered for the first time in this state on or after July 1,
862 2005, the carrier files with the commissioner the information and
863 statement required in subparagraph [(A)] (B)(i) of this subdivision at
864 least thirty days prior to the date such policy is issued or delivered in
865 this state.

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

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

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

873 [(e)] (5) "Self-insurer" or "self-insured or self-funded employee
874 health benefit plan" means an employer or an employee welfare
875 benefit fund or plan [which] that provides payment for or
876 reimbursement of the whole or any part of the cost of covered hospital
877 or medical expenses for covered individuals. [For purposes of sections
878 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "self-insurer" shall]
879 "Self-insurer" or "self-insured or self-funded employee health benefit
880 plan" does not include any such employee welfare benefit fund or plan
881 established prior to April 1, 1976, by any organization [which] that is
882 exempt from federal income taxes under the provisions of Section 501
883 of the United States Internal Revenue Code and amendments thereto
884 and legal interpretations thereof, except any such organization
885 described in Subsection (c)(15) of said Section 501.

886 [(f)] (6) "Commissioner" means the Insurance Commissioner. [of the
887 state of Connecticut.]

888 [(g)] "Physician" means a doctor of medicine, chiropractic,
889 naturopathy, podiatry, a qualified psychologist and, for purposes of
890 oral surgery only, a doctor of dental surgery or a doctor of medical
891 dentistry and, subject to the provisions of section 20-138d, optometrists
892 duly licensed under the provisions of chapter 380.

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

897 (i) "Skilled nursing facility" has the same meaning as "skilled
898 nursing facility", as defined in Section 1395x, Chapter 7 of Title 42,
899 United States Code.

900 (j) "Hospital" has the same meaning as "hospital", as defined in
901 Section 1395x, Chapter 7 of Title 42, United States Code.

902 (k) "Home health agency" has the same meaning as "home health
903 agency", as defined in Section 1395x, Chapter 7 of Title 42, United
904 States Code.

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

908 [(m)] (Z) "Resident employer" means any person, partnership,
909 association, trust, estate, limited liability company, corporation,
910 whether foreign or domestic, or the legal representative, trustee in
911 bankruptcy or receiver or trustee, thereof, or the legal representative of
912 a deceased person, including the state of Connecticut and each
913 municipality therein [, which] that has in its employ one or more
914 individuals during any calendar year, commencing January 1, 1976.
915 [For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559,
916 inclusive, the term "resident employer" shall refer] "Resident
917 employer" refers only to an employer with a majority of employees
918 employed within the state of Connecticut.

919 [(n) "Eligible employee" means, with respect to any employer, an
920 employee who either is considered a full-time employee, or who is
921 expected to work at least twenty hours a week for at least twenty-six
922 weeks during the next twelve months or who has actually worked at
923 least twenty hours a week for at least twenty-six weeks in any
924 continuous twelve-month period.

925 (o) "Alcoholism treatment facility" has the same meaning as
926 provided in section 38a-533.

927 (p) "Totally disabled" means with respect to an employee, the
928 inability of the employee because of an injury or disease to perform the
929 duties of any occupation for which he is suited by reason of education,
930 training or experience, and, with respect to a dependent, the inability
931 of the dependent because of an injury or disease to engage in
932 substantially all of the normal activities of persons of like age and sex
933 in good health.

934 (q) "Deductible" means the amount of covered expenses that must
935 be accumulated during each calendar year before benefits become
936 payable as additional covered expenses incurred.

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

940 (s) "Complications of pregnancy" means (1) conditions requiring
941 hospital stays, when the pregnancy is not terminated, whose diagnoses
942 are distinct from pregnancy but are adversely affected by pregnancy or
943 are caused by pregnancy, such as acute nephritis, nephrosis, cardiac
944 decompensation, missed abortion and similar medical and surgical
945 conditions of comparable severity, and shall not include false labor,
946 occasional spotting, physician-prescribed rest during the period of
947 pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia
948 and similar conditions associated with management of a difficult
949 pregnancy not constituting a nosologically distinct complication of
950 pregnancy; and (2) nonelective caesarean section, ectopic pregnancy
951 which is terminated, and spontaneous termination of pregnancy,
952 which occurs during a period of gestation in which a viable birth is not
953 possible.]

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

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

962 (v) "Health care tax credit eligible individual" means a person who
963 is eligible for the credit for health insurance costs under Section 35 of
964 the Internal Revenue Code of 1986 in accordance with the Pension
965 Benefit Guaranty Corporation and Trade Adjustment Assistance

966 programs of the Trade Act of 2002 (P.L. 107-210).]

967 (9) "Special health care plan" means a health insurance plan issued
968 by the Health Reinsurance Association established under section 38a-
969 556, as amended by this act, for low-income individuals.

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

975 (11) "Reimbursement rate" means, with respect to an individual
976 special health care plan, (A) seventy-five per cent of the
977 reimbursement rate payable under Medicare for benefits normally
978 reimbursable under Medicare, or (B) for services and supplies that are
979 not reimbursed by Medicare, seventy-five per cent of the amount that
980 would be payable under Medicare if Medicare was responsible for
981 payment for such services or supplies, as estimated by the board of
982 directors of the Health Reinsurance Association and approved by the
983 commissioner.

984 Sec. 14. Section 38a-552 of the general statutes is repealed and the
985 following is substituted in lieu thereof (*Effective from passage*):

986 [(a) (1) Every carrier offering individual health insurance in this
987 state shall, as a condition of transacting such health insurance, make an
988 individual comprehensive health care plan, described in section 38a-
989 555, available to every resident of this state except residents who are
990 both sixty-five years of age or older and eligible for Medicare.
991 Individual comprehensive health care plans may be made available
992 through participation in the Health Reinsurance Association in
993 accordance with section 38a-556, or a residual market association, in
994 accordance with section 38a-557. The premium charged for such a plan
995 which is not insured by or through the Health Reinsurance Association
996 or any other residual market association may not exceed the premium
997 which would be applicable through participation in such associations.

998 The premium charged for such a plan insured by or through the
999 Health Reinsurance Association shall be precisely the premium
1000 established for that particular classification under the Health
1001 Reinsurance Association. (2) Every self-insurer whose plan covers
1002 three or more employees shall make an individual comprehensive
1003 health care plan, described in section 38a-555, available under a
1004 conversion privilege to every person covered by the plan who is a
1005 resident of this state, who is not eligible for Medicare and whose
1006 coverage under the self-insured plan ceases as a result of layoff, death
1007 or termination of employment. The individual comprehensive health
1008 care plans may be provided through a carrier or through participation
1009 in the Health Reinsurance Association in accordance with section 38a-
1010 556. The premium charged for such a plan which is not insured by or
1011 through the Health Reinsurance Association may not exceed the
1012 premium established for that particular classification under the Health
1013 Reinsurance Association. The premium charged for such a plan which
1014 is insured by or through the Health Reinsurance Association shall be
1015 precisely the premium established for that particular classification
1016 under the Health Reinsurance Association.

1017 (b) Every carrier offering group health insurance in this state shall,
1018 as a condition of transacting such health insurance, make a group
1019 comprehensive health care plan, as described in section 38a-554,
1020 available to every resident employer who is not a small employer as
1021 defined in subdivision (4) of section 38a-564.

1022 (c) Except as provided in subdivision (c) of section 38a-505, nothing
1023 in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, shall
1024 preclude the right of carriers to transact other kinds of insurance for
1025 which they are authorized, nor preclude the right of carriers to transact
1026 any other lawful kind of health insurance.

1027 (d) Nothing in sections 38a-505, 38a-546 and 38a-551 to 38a-559,
1028 inclusive, shall require a carrier to make available coverage under a
1029 group or individual comprehensive health care plan to any person or
1030 group who is already covered under such a plan.]

1031 No individual or organization that provides medical advice,
1032 diagnosis, care or treatment of a type covered under a special health
1033 care plan shall provide such service to any person in this state unless
1034 such individual or organization provides such service, upon request,
1035 on the basis of the applicable reimbursement rate, to low-income
1036 individuals or their dependents covered under such special health care
1037 plans.

1038 Sec. 15. Section 38a-556 of the general statutes is repealed and the
1039 following is substituted in lieu thereof (*Effective from passage*):

1040 (a) There is hereby created a nonprofit legal entity to be known as
1041 the Health Reinsurance Association. All insurers, health care centers
1042 and self-insurers doing business in the state, as a condition to their
1043 authority to transact the applicable kinds of health insurance defined
1044 in section 38a-551, as amended by this act, shall be members of the
1045 association. The association shall perform its functions under a plan of
1046 operation established and approved under subsection [(a)] (b) of this
1047 section, and shall exercise its powers through a board of directors
1048 established under this section.

1049 [(a)] (b) (1) The board of directors of the association shall be made
1050 up of nine individuals selected by participating members, subject to
1051 approval by the commissioner, two of whom shall be appointed by the
1052 commissioner on or before July 1, 1993, to represent health care
1053 centers. To select the initial board of directors, and to initially organize
1054 the association, the commissioner shall give notice to all members of
1055 the time and place of the organizational meeting. In determining
1056 voting rights at the organizational meeting each member shall be
1057 entitled to vote in person or proxy. The vote shall be a weighted vote
1058 based upon the net health insurance premium derived from this state
1059 in the previous calendar year. If the board of directors is not selected
1060 within sixty days after notice of the organizational meeting, the
1061 commissioner may appoint the initial board. In approving or selecting
1062 members of the board, the commissioner may consider, among other
1063 things, whether all members are fairly represented. Members of the

1064 board may be reimbursed from the moneys of the association for
1065 expenses incurred by them as members, but shall not otherwise be
1066 compensated by the association for their services.

1067 (2) The board shall submit to the commissioner a plan of operation
1068 for the association necessary or suitable to assure the fair, reasonable
1069 and equitable administration of the association. The plan of operation
1070 shall become effective upon approval in writing by the commissioner,
1071 [consistent with the date on which the coverage under sections 38a-
1072 505, 38a-546 and 38a-551 to 38a-559, inclusive, must be made available.
1073 The commissioner shall, after notice and hearing, approve the plan of
1074 operation provided such plan is determined to be suitable to assure the
1075 fair, reasonable and equitable administration of the association, and
1076 provides for the sharing of association gains or losses on an equitable
1077 proportionate basis. If the board fails to submit a suitable plan of
1078 operation within one hundred eighty days after its appointment, or if
1079 at any time thereafter the board fails to submit suitable amendments to
1080 the plan, the commissioner shall, after notice and hearing, adopt and
1081 promulgate such reasonable rules as are necessary or advisable to
1082 effectuate the provisions of this section. Such rules] Such plan shall
1083 continue in force until modified by the commissioner or superseded by
1084 a plan submitted by the board and approved by the commissioner. The
1085 plan of operation shall: [, in addition to requirements enumerated in
1086 sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive:] (A)
1087 Establish procedures for the handling and accounting of assets and
1088 moneys of the association; (B) establish regular times and places for
1089 meetings of the board of directors; (C) establish procedures for records
1090 to be kept of all financial transactions, and for the annual fiscal
1091 reporting to the commissioner; (D) establish procedures whereby
1092 selections for the board of directors shall be made and submitted to the
1093 commissioner; (E) establish procedures to amend, subject to the
1094 approval of the commissioner, the plan of operations; (F) establish
1095 procedures for the selection of an administrator and set forth the
1096 powers and duties of the administrator; (G) contain additional
1097 provisions necessary or proper for the execution of the powers and
1098 duties of the association; and (H) [establish procedures for the

1099 advertisement on behalf of all participating carriers of the general
1100 availability of the comprehensive coverage under sections 38a-505,
1101 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional
1102 provisions necessary for the association to qualify as an acceptable
1103 alternative mechanism in accordance with Section 2744 of the Public
1104 Health Service Act, as set forth in the Health Insurance Portability and
1105 Accountability Act of 1996, P.L. 104-191; and (J)] contain additional
1106 provisions necessary for the association to establish health insurance
1107 plans that qualify as acceptable coverage in accordance with the
1108 Pension Benefit Guaranty Corporation and [Trade Adjustment
1109 Assistance programs of the Trade Act of 2002, P.L. 107-210. The
1110 commissioner may adopt regulations, in accordance with the
1111 provisions of chapter 54, to establish criteria for the association to
1112 qualify as an acceptable alternative mechanism] other state or federal
1113 programs that may be established.

1114 [(b)] (c) The association shall have the general powers and authority
1115 granted under the laws of this state to carriers to transact the kinds of
1116 insurance defined under section 38a-551, as amended by this act, and
1117 in addition thereto, the specific authority to: (1) Enter into contracts
1118 necessary or proper to carry out the provisions and purposes of this
1119 section and sections [38a-505, 38a-546 and] 38a-551, as amended by this
1120 act, and 38a-556a to 38a-559, inclusive; (2) sue or be sued, including
1121 taking any legal actions necessary or proper for recovery of any
1122 assessments for, on behalf of, or against participating members; (3)
1123 take such legal action as necessary to avoid the payment of improper
1124 claims against the association or the coverage provided by or through
1125 the association; (4) establish, with respect to health insurance provided
1126 by or on behalf of the association, appropriate rates, scales of rates, rate
1127 classifications and rating adjustments, such rates not to be
1128 unreasonable in relation to the coverage provided and the operational
1129 expenses of the association; (5) administer any type of reinsurance
1130 program, for or on behalf of participating members; (6) pool risks
1131 among participating members; (7) issue policies of insurance [on an
1132 indemnity or provision of service basis providing the coverage]
1133 required or permitted by this section and sections [38a-505, 38a-546

1134 and] 38a-551, as amended by this act, and 38a-556a to 38a-559,
1135 inclusive, in its own name or on behalf of participating members; (8)
1136 administer separate pools, separate accounts or other plans as deemed
1137 appropriate for separate members or groups of members; (9) operate
1138 and administer any combination of plans, pools, reinsurance
1139 arrangements or other mechanisms as deemed appropriate to best
1140 accomplish the fair and equitable operation of the association; (10) set
1141 limits on the amounts of reinsurance that may be ceded to the
1142 association by its members; (11) appoint from among participating
1143 members appropriate legal, actuarial and other committees as
1144 necessary to provide technical assistance in the operation of the
1145 association, policy and other contract design, and any other function
1146 within the authority of the association; [and] (12) apply for and accept
1147 grants, gifts and bequests of funds from other states, federal and
1148 interstate agencies and independent authorities, private firms,
1149 individuals and foundations for the purpose of carrying out its
1150 responsibilities. Any such funds received shall be deposited in the
1151 General Fund and shall be credited to a separate nonlapsing account
1152 within the General Fund for the Health Reinsurance Association and
1153 may be used by the Health Reinsurance Association in the
1154 performance of its duties; and (13) perform such other duties and
1155 responsibilities as may be required by state or federal law or permitted
1156 by state or federal law and approved by the commissioner.

1157 [(c) Every member shall participate in the association in accordance
1158 with the provisions of this subsection. (1) A participating member shall
1159 determine the particular risks it elects to have written by or through
1160 the association. A member shall designate which of the following
1161 classes of risks it shall underwrite in the state, from which classes of
1162 risk it may elect to reinsure selected risks: (A) Individual, excluding
1163 group conversion; and (B) individual, including group conversion. (2)
1164 No member shall be permitted to select out individual lives from an
1165 employer group to be insured by or through the association. Members
1166 electing to administer risks that are insured by or through the
1167 association shall comply with the benefit determination guidelines and
1168 the accounting procedures established by the association. A risk

1169 insured by or through the association cannot be withdrawn by the
1170 participating member except in accordance with the rules established
1171 by the association. (3)]

1172 (d) Rates for coverage issued by or through the association shall not
1173 be excessive, inadequate or unfairly discriminatory. [Separate scales of
1174 premium rates based on age shall apply, but rates shall not be adjusted
1175 for area variations in provider costs. Premium rates shall take into
1176 consideration the substantial extra morbidity and administrative
1177 expenses for association risks, reimbursement or reasonable expenses
1178 incurred for the writing of association risks and the level of rates
1179 charged by insurers for groups of ten lives, provided incurred losses
1180 that result from provision of coverage in accordance with section 38a-
1181 537 shall not be considered. In no event shall the rate for a given
1182 classification or group be less than one hundred twenty-five per cent
1183 or more than one hundred fifty per cent of the average rate charged for
1184 that classification with similar characteristics under a policy covering
1185 ten lives.] All rates shall be promulgated by the association through an
1186 actuarial committee consisting of five persons who are members of the
1187 American Academy of Actuaries, shall be filed with the commissioner
1188 and may be disapproved within sixty days [from] after the filing
1189 thereof if excessive, inadequate or unfairly discriminatory.

1190 [(d)] (e) (1) Following the close of each fiscal year, the administrator
1191 shall determine the net premiums, reinsurance premiums less
1192 administrative expense allowance, the expense of administration
1193 pertaining to the reinsurance operations of the association and the
1194 incurred losses for the year. Any net loss shall be assessed to all
1195 participating members in proportion to their respective shares of the
1196 total health insurance premiums earned in this state during the
1197 calendar year, or with paid losses in the year, coinciding with or
1198 ending during the fiscal year of the association or on any other
1199 equitable basis as may be provided in the plan of operations. For self-
1200 insured members of the association, health insurance premiums
1201 earned shall be established by dividing the amount of paid health
1202 losses for the applicable period by eighty-five per cent. Net gains, if

1203 any, shall be held at interest to offset future losses or allocated to
1204 reduce future premiums.

1205 (2) Any net loss to the association represented by the excess of its
1206 actual expenses of administering policies issued by the association
1207 over the applicable expense allowance shall be separately assessed to
1208 those participating members who do not elect to administer their
1209 plans. All assessments shall be on an equitable formula established by
1210 the board.

1211 (3) The association shall conduct periodic audits to assure the
1212 general accuracy of the financial data submitted to the association and
1213 the association shall have an annual audit of its operations by an
1214 independent certified public accountant. The annual audit shall be
1215 filed with the commissioner for his review and the association shall be
1216 subject to the provisions of section 38a-14.

1217 [(4) For the fiscal year ending December 31, 1993, and the first
1218 quarter of the fiscal year ending December 31, 1994, the administrator
1219 shall not include health care centers in assessing any net losses to
1220 participating members.]

1221 [(e)] (f) All policy forms issued by or through the association shall
1222 conform in substance to prototype forms developed by the association,
1223 shall in all other respects conform to the requirements of this section
1224 and sections [38a-505, 38a-546 and] 38a-551, as amended by this act,
1225 and 38a-556a to 38a-559, inclusive, and shall be approved by the
1226 commissioner. The commissioner may disapprove any such form if it
1227 contains a provision or provisions [which] that are unfair or deceptive
1228 or [which] that encourage misrepresentation of the policy.

1229 [(f)] (g) Unless otherwise permitted by the plan of operation, the
1230 association shall not issue, reissue or continue in force
1231 [comprehensive] health care plan coverage with respect to any person
1232 who is already covered under an individual or group [comprehensive]
1233 health care plan, or who is sixty-five years of age or older and eligible
1234 for Medicare or who is not a resident of this state. [Coverage provided

1235 to a HIPAA or health care tax credit eligible individual may be
1236 terminated to the extent permitted by HIPAA or the Trade Act of 2002,
1237 respectively.]

1238 [(g)] (h) Benefits payable under a [comprehensive] health care plan
1239 insured by or reinsured through the association shall be paid net of all
1240 other health insurance benefits paid or payable through any other
1241 source, and net of all health insurance coverages provided by or
1242 pursuant to any other state or federal law including Title XVIII of the
1243 Social Security Act, Medicare, but excluding Medicaid.

1244 [(h)] (i) There shall be no liability on the part of and no cause of
1245 action of any nature shall arise against any carrier or its agents or its
1246 employees, the Health Reinsurance Association or its agents or its
1247 employees or the residual market mechanism established under the
1248 provisions of section 38a-557, as amended by this act, or its agents or
1249 its employees, or the commissioner or [his] the commissioner's
1250 representatives for any action taken by them in the performance of
1251 their duties under this section and sections [38a-505, 38a-546 and] 38a-
1252 551, as amended by this act, and 38a-556a to 38a-559, inclusive. This
1253 provision shall not apply to the obligations of a carrier, a self-insurer,
1254 the Health Reinsurance Association or the residual market mechanism
1255 for payment of benefits provided under a [comprehensive] health care
1256 plan.

1257 Sec. 16. Section 38a-557 of the general statutes is repealed and the
1258 following is substituted in lieu thereof (*Effective from passage*):

1259 (a) Hospital service corporations and medical service corporations
1260 may [elect to meet the obligations of section 38a-552 by participating]
1261 participate in the Health Reinsurance Association established in
1262 section 38a-556, as amended by this act, as a full member thereof, or by
1263 making [comprehensive] health care plans available directly through a
1264 subscriber contract or combination of contracts or by forming a
1265 separate residual market mechanism substantially similar to [the
1266 association established in section 38a-556] said association.

1267 (b) In the event that hospital service corporations and medical
1268 service corporations choose to form a separate residual market
1269 mechanism, the commissioner shall have the same regulatory powers
1270 over that residual market mechanism as the commissioner has over the
1271 Health Reinsurance Association, and such residual market mechanism
1272 shall have the same powers and duties as the association. Rating
1273 classifications under a residual market mechanism established under
1274 this section need not be the same as classifications established under
1275 the association, but any rates established by the residual market
1276 mechanism shall be approved by the commissioner. The commissioner
1277 shall ~~[promulgate]~~ adopt regulations, in accordance with the
1278 provisions of chapter 54, to carry out the requirements of this section.

1279 (c) If hospital service corporations and medical service corporations
1280 do not elect to participate in the Health Reinsurance Association, such
1281 service corporations shall be required to make an individual
1282 [comprehensive] health care plan available to every resident of this
1283 state except residents who are both sixty-five years of age or older and
1284 eligible for Medicare and whose coverage under a group or individual
1285 contract issued by such service corporations has terminated. Such
1286 coverage may be made available through a separate residual market
1287 mechanism established under this section.

1288 Sec. 17. Section 38a-564 of the general statutes is repealed and the
1289 following is substituted in lieu thereof (*Effective from passage*):

1290 As used in this section and sections [12-201, 12-211, 12-212a and 38a-
1291 565 to 38a-572, inclusive] 38a-566, as amended by this act, 38a-567, as
1292 amended by this act, 38a-569, as amended by this act, and 38a-574, as
1293 amended by this act:

1294 (1) "Pool" means the Connecticut Small Employer Health
1295 Reinsurance Pool, established under section 38a-569, as amended by
1296 this act.

1297 (2) "Board" means the board of directors of the pool.

1298 [(3) "Eligible employee" means an employee who works a normal
1299 work week of twenty or more hours and includes a sole proprietor, a
1300 partner of a partnership or an independent contractor, provided such
1301 sole proprietor, partner or contractor is included as an employee under
1302 a health care plan of a small employer but does not include an
1303 employee who works on a seasonal, temporary or substitute basis.
1304 "Eligible employee" shall include any employee who is not actively at
1305 work but is covered under the small employer's health insurance plan
1306 pursuant to (A) workers' compensation, (B) continuation of benefits
1307 pursuant to section 38a-554, or (C) other applicable laws.

1308 (4) (A) "Small employer" means any person, firm, corporation,
1309 limited liability company, partnership or association actively engaged
1310 in business or self-employed for at least three consecutive months
1311 who, on at least fifty per cent of its working days during the preceding
1312 twelve months, employed no more than fifty eligible employees, the
1313 majority of whom were employed within the state of Connecticut.
1314 "Small employer" includes a self-employed individual. For the
1315 purposes of determining the number of eligible employees under this
1316 subdivision: (i) Companies that are affiliated companies, as defined in
1317 section 33-840, or that are eligible to file a combined tax return for
1318 purposes of taxation under chapter 208 shall be considered one
1319 employer; (ii) employees covered through the employer by health
1320 insurance plans or insurance arrangements issued to or in accordance
1321 with a trust established pursuant to collective bargaining subject to the
1322 federal Labor Management Relations Act shall not be counted; (iii)
1323 employees who are not actively at work but are covered under the
1324 small employer's health insurance plan pursuant to workers'
1325 compensation, continuation of benefits pursuant to section 38a-554 or
1326 other applicable laws shall not be counted; and (iv) employees who
1327 work a normal work week of less than thirty hours shall not be
1328 counted. Except as otherwise specifically provided, provisions of this
1329 section and sections 12-201, 12-211, 12-212a and 38a-565 to 38a-572,
1330 inclusive, that apply to a small employer shall continue to apply until
1331 the plan anniversary following the date the employer no longer meets
1332 the requirements of this definition.

1333 (B) "Small employer" does not include (i) a municipality procuring
1334 health insurance pursuant to section 5-259, (ii) a private school in this
1335 state procuring health insurance through a health insurance plan or an
1336 insurance arrangement sponsored by an association of such private
1337 schools, (iii) a nonprofit organization procuring health insurance
1338 pursuant to section 5-259, unless the Secretary of the Office of Policy
1339 and Management and the State Comptroller make a request in writing
1340 to the Insurance Commissioner that such nonprofit organization be
1341 deemed a small employer for the purposes of this chapter, (iv) an
1342 association for personal care assistants procuring health insurance
1343 pursuant to section 5-259, or (v) a community action agency procuring
1344 health insurance pursuant to section 5-259.]

1345 (3) "Employee" means an individual employed by an employer.
1346 "Employee" does not include (A) an individual and such individual's
1347 spouse with respect to an incorporated or unincorporated trade or
1348 business that is wholly owned by such individual, by such individual's
1349 spouse or by such individual and such individual's spouse, or (B) a
1350 partner in a partnership and such partner's spouse with respect to such
1351 partnership.

1352 (4) (A) "Small employer" means an employer that, (i) prior to
1353 January 1, 2016, employed an average of at least one but not more than
1354 fifty employees on business days during the preceding calendar year
1355 and employs at least one employee on the first day of the group health
1356 insurance plan year, and (ii) on and after January 1, 2016, employed an
1357 average of at least one but not more than one hundred employees on
1358 business days during the preceding calendar year and employs at least
1359 one employee on the first day of the group health insurance plan year.
1360 "Small employer" does not include a sole proprietorship that employs
1361 only the sole proprietor or the spouse of such sole proprietor.

1362 (B) (i) For purposes of subparagraph (A) of this subdivision, the
1363 number of employees shall be determined by adding (I) the number of
1364 full-time employees for each month who work a normal work week of
1365 thirty hours or more, and (II) the number of full-time equivalent

1366 employees, calculated for each month by dividing by one hundred
1367 twenty the aggregate number of hours worked for such month by
1368 employees who work a normal work week of less than thirty hours,
1369 and averaging such total for the calendar year.

1370 (ii) If an employer was not in existence throughout the preceding
1371 calendar year, the number of employees shall be based on the average
1372 number of employees that such employer reasonably expects to
1373 employ in the current calendar year.

1374 (C) All persons treated as a single employer under Section 414 of the
1375 Internal Revenue Code of 1986, or any subsequent corresponding
1376 internal revenue code of the United States, as amended from time to
1377 time, shall be considered a single employer for purposes of this
1378 subdivision.

1379 (5) "Insurer" means any insurance company, hospital [or] service
1380 corporation, medical service corporation [,] or health care center,
1381 authorized to transact health insurance business in this state.

1382 (6) "Insurance arrangement" means any multiple employer welfare
1383 arrangement, as defined in Section 3 of the Employee Retirement
1384 Income Security Act of 1974, as amended from time to time, except for
1385 any such arrangement that is fully insured within the meaning of
1386 Section 514(b)(6) of said act, as amended from time to time.

1387 (7) "Health insurance plan" means any hospital and medical expense
1388 incurred policy, hospital or medical service plan contract and health
1389 care center subscriber contract. [and] "Health insurance plan" does not
1390 include (A) accident only, credit, dental, vision, Medicare supplement,
1391 long-term care or disability insurance, hospital indemnity coverage,
1392 coverage issued as a supplement to liability insurance, insurance
1393 arising out of a workers' compensation or similar law, automobile
1394 medical-payments insurance, or insurance under which beneficiaries
1395 are payable without regard to fault and which is statutorily required to
1396 be contained in any liability insurance policy or equivalent self-
1397 insurance, or (B) policies of specified disease or limited benefit health

1398 insurance, provided that the carrier offering such policies files on or
1399 before March first of each year a certification with the commissioner
1400 that contains the following: (i) A statement from the carrier certifying
1401 that such policies are being offered and marketed as supplemental
1402 health insurance and not as a substitute for hospital or medical
1403 expense insurance; (ii) a summary description of each such policy
1404 including the average annual premium rates, or range of premium
1405 rates in cases where premiums vary by age, gender or other factors,
1406 charged for such policies in the state; and (iii) in the case of a policy
1407 that is described in this subparagraph and that is offered for the first
1408 time in this state on or after October 1, 1993, the carrier files with the
1409 commissioner the information and statement required in this
1410 subparagraph at least thirty days prior to the date such policy is issued
1411 or delivered in this state.

1412 (8) "Plan of operation" means the plan of operation of the pool,
1413 including articles, bylaws and operating rules, adopted by the board
1414 pursuant to section 38a-569, as amended by this act.

1415 [(9) "Late enrollee" means an eligible employee or dependent who
1416 requests enrollment in a small employer's health insurance plan
1417 following the initial enrollment period provided under the terms of the
1418 first plan for which such employee or dependent was eligible through
1419 such small employer, provided an eligible employee or dependent
1420 shall not be considered a late enrollee if (A) the request for enrollment
1421 is made within thirty days after termination of coverage provided
1422 under another group health insurance plan and if the individual had
1423 not initially requested coverage under such plan solely because he was
1424 covered under another group health insurance plan and coverage
1425 under that plan has ceased due to termination of employment, death of
1426 a spouse, or divorce, or due to that plan's involuntary termination or
1427 cancellation by its carrier for reasons other than nonpayment of
1428 premium, or (B) the individual is employed by an employer who offers
1429 multiple health insurance plans and the individual elects a different
1430 health insurance plan during an open enrollment period, or (C) a court
1431 has ordered coverage be provided for a spouse or minor child under a

1432 covered employee's plan and request for enrollment is made within
1433 thirty days after issuance of such court order, or (D) if the request for
1434 enrollment is made within thirty days after the marriage of such
1435 employee or the birth or adoption of the first child by such employee
1436 after the later of the commencement of the employer's plan or the date
1437 the pool becomes operational, and satisfactory evidence of such
1438 marriage, birth or adoption is provided to the small employer carrier.

1439 (10) "Department" means the Insurance Department.

1440 (11) "Special health care plan" means a health insurance plan for
1441 previously uninsured small employers, established by the board in
1442 accordance with section 38a-565 or by the Health Reinsurance
1443 Association in accordance with section 38a-570.

1444 (12) "Small employer health care plan" means a health insurance
1445 plan for small employers, established by the board in accordance with
1446 section 38a-568.]

1447 [(13)] (9) "Dependent" means the spouse or child of an eligible
1448 employee, subject to applicable terms of the health insurance plan
1449 covering such employee. "Dependent" [shall also include] includes any
1450 dependent [that] who is covered under the small employer's health
1451 insurance plan pursuant to workers' compensation, continuation of
1452 benefits pursuant to section [38a-554] 38a-512a, as amended by this act,
1453 or other applicable laws.

1454 [(14)] (10) "Commissioner" means the Insurance Commissioner.

1455 [(15)] (11) "Member" means each insurer and insurance arrangement
1456 participating in the pool.

1457 [(16)] (12) "Small employer carrier" means any insurer or insurance
1458 arrangement [which] that offers or maintains group health insurance
1459 plans covering eligible employees of one or more small employers.

1460 [(17) "Preexisting conditions provision" means a policy provision
1461 that excludes coverage for charges or expenses incurred during a

1462 specified period following the insured's effective date of coverage as to
1463 a condition that, during a specified period immediately preceding the
1464 effective date of coverage, had manifested itself in such a manner as
1465 would cause an ordinary prudent person to seek diagnosis, care or
1466 treatment or for which medical advice, diagnosis, care or treatment
1467 was recommended or received as to that condition.

1468 (18) "Base premium rate" means, as to any health insurance plan or
1469 insurance arrangement covering one or more employees of a small
1470 employer, the lowest new business premium rate charged by the
1471 insurer or insurance arrangement for the same or similar coverage
1472 which is equivalent in value under a plan or arrangement covering any
1473 small employer with similar case characteristics, other than claim
1474 experience, as determined by such insurer or insurance arrangement,
1475 except that as to any small employer carrier or insurance arrangement
1476 not issuing new health insurance plans or insurance arrangements to a
1477 small employer, "base premium rate" means the lowest rate charged a
1478 small employer for the same or similar coverage which is equivalent in
1479 value, under a plan or arrangement covering any small employer with
1480 similar case characteristics, other than claim experience, as determined
1481 by such insurer or insurance arrangement.

1482 (19) "Low-income eligible employee" means an eligible employee of
1483 a small employer whose annualized wages from such small employer
1484 determined as of the effective date of the special health care plan or as
1485 of any anniversary of such effective date as certified to the insurer or
1486 insurance arrangement or the Health Reinsurance Association, as the
1487 case may be, by such small employer is less than three hundred per
1488 cent of the federal poverty level applicable to such person.

1489 (20) "Medicare" means the Health Insurance for the Aged Act, Title
1490 XVIII of the Social Security Amendments of 1965, as amended from
1491 time to time.

1492 (21) "Health Reinsurance Association" means the entity established
1493 and maintained in accordance with the provisions of sections 38a-505,
1494 38a-546 and 38a-551 to 38a-559, inclusive.

1495 (22) "Reimbursement rate" means, as to individuals covered under
1496 special health care plans or an individual special health care plan,
1497 seventy-five per cent of the Medicare reimbursement rate for benefits
1498 normally reimbursable under Medicare. For services or supplies not
1499 reimbursed by Medicare, such reimbursement shall be seventy-five per
1500 cent of the amount which would be payable under Medicare, if
1501 Medicare was responsible for benefit payments under such plans for
1502 such services and supplies, as determined by the board and approved
1503 by the commissioner.

1504 (23) "Individual special health care plan" means a health insurance
1505 plan for individuals, issued by the Health Reinsurance Association in
1506 accordance with section 38a-571 or issued by an insurer in accordance
1507 with section 38a-565.

1508 (24) "Low-income individual" means an individual whose adjusted
1509 gross income (AGI) for the individual and spouse, from the most
1510 recent federal tax return filed prior to the date of application for the
1511 individual special health care plan or prior to any anniversary of the
1512 effective date of the plan, as certified by such individual, is less than
1513 three hundred per cent of the applicable federal poverty level.

1514 (25) "Medicare reimbursement rate" means the amount which
1515 would be payable under Medicare for benefits normally reimbursed
1516 under Medicare.]

1517 [(26)] (13) "Health care center" [means health care center as defined]
1518 has the same meaning as provided in section 38a-175.

1519 [(27)] (14) "Case characteristics" means demographic or other
1520 objective characteristics of a small employer, including age [, sex,
1521 family composition, location, size of group, administrative cost savings
1522 resulting from the administration of an association group plan or a
1523 plan written pursuant to section 5-259 and industry classification, as
1524 determined by a small employer carrier, that are considered by the
1525 small employer carrier in the determination of premium rates for the
1526 small employer. Claim] and geographic location. "Case characteristics"

1527 does not include claims experience, health status [, and] or duration of
1528 coverage since issue. [are not case characteristics for the purpose of
1529 sections 38a-564 to 38a-572, inclusive.]

1530 [(28) "Actuarial certification" means a written statement by a
1531 member of the American Academy of Actuaries or other individual
1532 acceptable to the commissioner that a small employer carrier is in
1533 compliance with the provisions of subdivisions (4), (6), (7) and (9) of
1534 section 38a-567 and the regulations promulgated by the commissioner
1535 pursuant to section 38a-567, based upon the person's examination,
1536 including a review of the appropriate records and of the actuarial
1537 assumptions and methods used by the small employer carrier in
1538 establishing premium rates for applicable health benefit plans.]

1539 Sec. 18. Section 38a-566 of the general statutes is repealed and the
1540 following is substituted in lieu thereof (*Effective from passage*):

1541 (a) Any individual or group health insurance plan or any insurance
1542 arrangement shall be subject to the provisions of sections [12-201, 12-
1543 211, 12-212a and 38a-564 to 38a-572, inclusive] 38a-552, as amended by
1544 this act, 38a-564, as amended by this act, 38a-567, as amended by this
1545 act, and 38a-569, as amended by this act, if it provides health insurance
1546 or is an insurance arrangement covering one or more employees of a
1547 small employer and if any one of the following conditions are met:

1548 (1) Any portion of the premium or benefits is paid by a small
1549 employer or any covered individual is reimbursed, whether through
1550 wage adjustments or otherwise, by a small employer for any portion of
1551 the premium; or

1552 (2) The health insurance plan or arrangement is treated by the
1553 employer or any of the covered individuals as part of a plan or
1554 program for the purposes of Section 162 or Section 106 of the United
1555 States Internal Revenue Code.

1556 (b) Nothing in this section shall be construed to apply the provisions
1557 of sections 12-202 and 12-212a, as amended by this act, to health care

1558 centers.

1559 (c) Notwithstanding the provisions of subsection (a) of this section,
1560 health insurance plans or insurance arrangements issued to or in
1561 accordance with a trust established pursuant to collective bargaining,
1562 subject to the federal Labor Management Relations Act and which
1563 cover, in the aggregate, more than twenty-five employees of all
1564 participating employers, shall not be subject to the provisions of
1565 section 38a-567, as amended by this act, or subparagraph (A) of
1566 subdivision (2) of subsection [(e)] (c) of section 38a-569, as amended by
1567 this act. [and insurers or insurance arrangements issuing only such
1568 plans shall not be considered small employer carriers for purposes of
1569 sections 38a-565 and 38a-568.]

1570 (d) A small employer carrier that ceases marketing to small
1571 employers [as provided in subsection (d) of section 38a-568] shall not
1572 cease enrolling new employers in a policy issued to provide coverage
1573 to the members of a trade association or to a trust on behalf of a trade
1574 association if the following conditions exist:

1575 (1) Such trade association is a not-for-profit trade association
1576 qualified under 26 USC Section 501c(6), was not formed solely for the
1577 purpose of providing insurance and has been operating continuously
1578 for at least twenty-five years; [.]

1579 (2) The policy issued to or on behalf of such association was in
1580 existence prior to June 1, 1990, and has annual premiums of less than
1581 twenty-five million dollars; [.]

1582 (3) Such policy is offered on a guaranteed issue basis to all small
1583 employer members and only to members of such trade association.

1584 [(e) Subsection (a) of this section shall not apply to an individual
1585 health insurance plan issued to a self-employed individual if the
1586 carrier discloses on the application and marketing materials, in not less
1587 than ten-point type, the following notice: "THIS PLAN IS ISSUED ON
1588 AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL

1589 HEALTH INSURANCE PLAN.]"

1590 Sec. 19. Section 38a-567 of the general statutes is repealed and the
1591 following is substituted in lieu thereof (*Effective from passage*):

1592 Health insurance plans, associations of small employers and other
1593 insurance arrangements covering small employers and insurers and
1594 producers marketing such plans and arrangements shall be subject to
1595 the following provisions:

1596 [(1) (A) (i) Any such insurer or producer marketing such plans or
1597 arrangements shall offer premium quotes to small employers upon
1598 request for coverage for employees who work a normal work week of
1599 thirty or more hours. Upon request by a small employer, such insurer
1600 or producer shall offer premium quotes for coverage for employees
1601 that include those who work a normal work week of at least twenty
1602 hours.

1603 (ii) No small employer that has requested premium quotes for
1604 coverage for employees that include those who work a normal work
1605 week of less than thirty hours shall be required to accept such quotes
1606 or coverage in lieu of premium quotes or coverage for only those
1607 employees who work a normal work week of thirty or more hours.

1608 (iii) Nothing in this subparagraph shall require a small employer
1609 that offers coverage to its employees who work a normal work week of
1610 thirty hours or more to offer coverage to its employees who work a
1611 normal work week of less than thirty hours.]

1612 (1) (A) Any such plan or arrangement shall be offered on a
1613 guaranteed issue basis with respect to all eligible employees or
1614 dependents of such employees, at the option of the small employer,
1615 policyholder or contractholder, as the case may be.

1616 (B) Any such plan or arrangement shall be renewable with respect
1617 to all eligible employees or dependents at the option of the small
1618 employer, policyholder or contractholder, as the case may be, except:
1619 (i) For nonpayment of the required premiums by the small employer,

1620 policyholder or contractholder; (ii) for fraud or misrepresentation of
1621 the small employer, policyholder or contractholder or, with respect to
1622 coverage of individual insured, the insureds or their representatives;
1623 (iii) for noncompliance with plan or arrangement provisions; (iv) when
1624 the number of insureds covered under the plan or arrangement is less
1625 than the number of insureds or percentage of insureds required by
1626 participation requirements under the plan or arrangement; or (v) when
1627 the small employer, policyholder or contractholder is no longer
1628 actively engaged in the business in which it was engaged on the
1629 effective date of the plan or arrangement.

1630 (C) Renewability of coverage may be effected by either continuing
1631 in effect a plan or arrangement covering a small employer or by
1632 substituting upon renewal for the prior plan or arrangement the plan
1633 or arrangement then offered by the carrier that most closely
1634 corresponds to the prior plan or arrangement and is available to other
1635 small employers. Such substitution shall only be made under
1636 conditions approved by the commissioner. A carrier may substitute a
1637 plan or arrangement as [stated above] set forth in this subparagraph
1638 only if the carrier effects the same substitution upon renewal for all
1639 small employers previously covered under the particular plan or
1640 arrangement, unless otherwise approved by the commissioner. The
1641 substitute plan or arrangement shall be subject to the rating restrictions
1642 specified in this section on the same basis as if no substitution had
1643 occurred, except for an adjustment based on coverage differences.

1644 [(D) Notwithstanding the provisions of this subdivision, any such
1645 plan or arrangement, or any coverage provided under such plan or
1646 arrangement may be rescinded for fraud, intentional material
1647 misrepresentation or concealment by an applicant, employee,
1648 dependent or small employer.

1649 (E) Any individual who was not a late enrollee at the time of his or
1650 her enrollment and whose coverage is subsequently rescinded shall be
1651 allowed to reenroll as of a current date in such plan or arrangement
1652 subject to any preexisting condition or other provisions applicable to

1653 new enrollees without previous coverage. On and after the effective
1654 date of such individual's reenrollment, the small employer carrier may
1655 modify the premium rates charged to the small employer for the
1656 balance of the current rating period and for future rating periods, to
1657 the level determined by the carrier as applicable under the carrier's
1658 established rating practices had full, accurate and timely underwriting
1659 information been supplied when such individual initially enrolled in
1660 the plan. The increase in premium rates allowed by this provision for
1661 the balance of the current rating period shall not exceed twenty-five
1662 per cent of the small employer's current premium rates. Any such
1663 increase for the balance of said current rating period shall not be
1664 subject to the rate limitation specified in subdivision (6) of this section.
1665 The rate limitation specified in this section shall otherwise be fully
1666 applicable for the current and future rating periods. The modification
1667 of premium rates allowed by this subdivision shall cease to be
1668 permitted for all plans and arrangements on the first rating period
1669 commencing on or after July 1, 1995.

1670 (2) Except in the case of a late enrollee who has failed to provide
1671 evidence of insurability satisfactory to the insurer, the plan or
1672 arrangement may not exclude any eligible employee or dependent
1673 who would otherwise be covered under such plan or arrangement on
1674 the basis of an actual or expected health condition of such person. No
1675 plan or arrangement may exclude an eligible employee or eligible
1676 dependent who, on the day prior to the initial effective date of the plan
1677 or arrangement, was covered under the small employer's prior health
1678 insurance plan or arrangement pursuant to workers' compensation,
1679 continuation of benefits pursuant to section 38a-554 or other applicable
1680 laws. The employee or dependent shall request coverage under the
1681 new plan or arrangement on a timely basis and such coverage shall
1682 terminate in accordance with the provisions of the applicable law.

1683 (3) (A) For rating periods commencing on or after October 1, 1993,
1684 and prior to July 1, 1994, the premium rates charged or offered for a
1685 rating period for all plans and arrangements may not exceed one
1686 hundred thirty-five per cent of the base premium rate for all plans or

1687 arrangements.

1688 (B) For rating periods commencing on or after July 1, 1994, and prior
1689 to July 1, 1995, the premium rates charged or offered for a rating
1690 period for all plans or arrangements may not exceed one hundred
1691 twenty per cent of the base premium rate for such rating period. The
1692 provisions of this subdivision shall not apply to any small employer
1693 who employs more than twenty-five eligible employees.

1694 (4) For rating periods commencing on or after October 1, 1993, and
1695 prior to July 1, 1995, the percentage increase in the premium rate
1696 charged to a small employer, who employs not more than twenty-five
1697 eligible employees, for a new rating period may not exceed the sum of:

1698 (A) The percentage change in the base premium rate measured from
1699 the first day of the prior rating period to the first day of the new rating
1700 period;

1701 (B) An adjustment of the small employer's premium rates for the
1702 prior rating period, and adjusted pro rata for rating periods of less
1703 than one year, due to the claim experience, health status or duration of
1704 coverage of the employees or dependents of the small employer, such
1705 adjustment (i) not to exceed ten per cent annually for the rating
1706 periods commencing on or after October 1, 1993, and prior to July 1,
1707 1994, and (ii) not to exceed five per cent annually for the rating periods
1708 commencing on or after July 1, 1994, and prior to July 1, 1995; and

1709 (C) Any adjustments due to change in coverage or change in the
1710 case characteristics of the small employer, as determined from the
1711 small employer carrier's applicable rate manual.]

1712 (D) Any such plan or arrangement shall provide special enrollment
1713 periods (i) to all eligible employees or dependents as set forth in 45
1714 CFR 147.104, as amended from time to time, and (ii) for coverage
1715 under such plan or arrangement ordered by a court for a spouse or
1716 minor child of an eligible employee where request for enrollment is
1717 made not later than thirty days after the issuance of such court order.

1718 [(5) (A)] (2) (A) As used in this subdivision, "grandfathered plan"
1719 has the same meaning as "grandfathered health plan" as provided in
1720 the Patient Protection and Affordable Care Act, P.L. 111-148, as
1721 amended from time to time.

1722 (B) With respect to grandfathered plans [or arrangements issued on
1723 or after July 1, 1995] issued to small employers, the premium rates
1724 charged or offered [to small employers] shall be established on the
1725 basis of a [community rate] single pool of all grandfathered plans,
1726 adjusted to reflect one or more of the following classifications:

1727 (i) Age, provided age brackets of less than five years shall not be
1728 utilized;

1729 (ii) Gender;

1730 (iii) Geographic area, provided an area smaller than a county shall
1731 not be utilized;

1732 (iv) Industry, provided the rate factor associated with any industry
1733 classification shall not vary from the arithmetic average of the highest
1734 and lowest rate factors associated with all industry classifications by
1735 greater than fifteen per cent of such average, and provided further, the
1736 rate factors associated with any industry shall not be increased by
1737 more than five per cent per year;

1738 (v) Group size, provided the highest rate factor associated with
1739 group size shall not vary from the lowest rate factor associated with
1740 group size by a ratio of greater than 1.25 to 1.0;

1741 (vi) Administrative cost savings resulting from the administration of
1742 an association group plan or a plan written pursuant to section 5-259,
1743 as amended by this act, provided the savings reflect a reduction to the
1744 small employer carrier's overall retention that is measurable and
1745 specifically realized on items such as marketing, billing or claims
1746 paying functions taken on directly by the plan administrator or
1747 association, except that such savings may not reflect a reduction
1748 realized on commissions;

1749 (vii) Savings resulting from a reduction in the profit of a carrier
1750 [who] that writes small business plans or arrangements for an
1751 association group plan or a plan written pursuant to section 5-259, as
1752 amended by this act, provided any loss in overall revenue due to a
1753 reduction in profit is not shifted to other small employers; and

1754 (viii) Family composition, provided the small employer carrier shall
1755 utilize only one or more of the following billing classifications: (I)
1756 Employee; (II) employee plus family; (III) employee and spouse; (IV)
1757 employee and child; (V) employee plus one dependent; and (VI)
1758 employee plus two or more dependents.

1759 [(B) The small employer carrier shall quote premium rates to small
1760 employers after receipt of all demographic rating classifications of the
1761 small employer group. No small employer carrier may inquire
1762 regarding health status or claims experience of the small employer or
1763 its employees or dependents prior to the quoting of a premium rate.

1764 (C) The provisions of subparagraphs (A) and (B) of this subdivision
1765 shall apply to plans or arrangements issued on or after July 1, 1995.
1766 The provisions of subparagraphs (A) and (B) of this subdivision shall
1767 apply to plans or arrangements issued prior to July 1, 1995, as of the
1768 date of the first rating period commencing on or after that date, but no
1769 later than July 1, 1996.

1770 (6) For any small employer plan or arrangement on which the
1771 premium rates for employee and dependent coverage or both, vary
1772 among employees, such variations shall be based solely on age and
1773 other demographic factors permitted under subparagraph (A) of
1774 subdivision (5) of this section and such variations may not be based on
1775 health status, claim experience, or duration of coverage of specific
1776 enrollees. Except as otherwise provided in subdivision (1) of this
1777 section, any adjustment in premium rates charged for a small
1778 employer plan or arrangement to reflect changes in case characteristics
1779 prior to the end of a rating period shall not include any adjustment to
1780 reflect the health status, medical history or medical underwriting
1781 classification of any new enrollee for whom coverage begins during

1782 the rating period.

1783 (7) For rating periods commencing prior to July 1, 1995, in any case
1784 where a small employer carrier utilized industry classification as a case
1785 characteristic in establishing premium rates, the rate factor associated
1786 with any industry classification shall not vary from the arithmetical
1787 average of the highest and lowest rate factors associated with all
1788 industry classifications by greater than fifteen per cent of such average.

1789 (8) Differences in base premium rates charged for health benefit
1790 plans by a small employer carrier shall be reasonable and reflect
1791 objective differences in plan design, not including differences due to
1792 the nature of the groups assumed to select particular health benefit
1793 plans.

1794 (9) For rating periods commencing prior to July 1, 1995, in any case
1795 where an insurer issues or offers a policy or contract under which
1796 premium rates for a specific small employer are established or
1797 adjusted in part based upon the actual or expected variation in claim
1798 costs or actual or expected variation in health conditions of the
1799 employees or dependents of such small employer, the insurer shall
1800 make reasonable disclosure of such rating practices in solicitation and
1801 sales materials utilized with respect to such policy or contract.

1802 (10) If a small employer carrier denies coverage as requested to a
1803 small employer that is self-employed, the small employer carrier shall
1804 promptly offer such small employer the opportunity to purchase a
1805 small employer health care plan. If a small employer carrier or any
1806 producer representing that carrier fails, for any reason, to offer
1807 coverage as requested by a small employer that is self-employed, that
1808 small employer carrier shall promptly offer such small employer an
1809 opportunity to purchase a small employer health care plan.]

1810 (C) (i) With respect to nongrandfathered plans issued to small
1811 employers, the premium rates charged or offered shall be established
1812 on the basis of a single pool of all nongrandfathered plans, adjusted to
1813 reflect one or more of the following classifications:

1814 (I) Age, in accordance with a uniform age rating curve established
1815 by the commissioner;

1816 (II) Geographic area, as defined by the commissioner.

1817 (ii) Total premium rates for family coverage for nongrandfathered
1818 plans shall be determined by adding the premiums for each individual
1819 family member, except that with respect to family members under
1820 twenty-one years of age, the premiums for only the three oldest
1821 covered children shall be taken into account in determining the total
1822 premium rate for such family.

1823 (iii) Premium rates for employees and dependents for
1824 nongrandfathered plans shall be calculated for each covered individual
1825 and premium rates for the small employer group shall be calculated by
1826 totaling the premiums attributable to each covered individual.

1827 (iv) Premium rates for any given plan may vary by actuarially
1828 justified differences in plan design.

1829 ~~[(11)]~~ (3) No small employer carrier or producer shall, directly or
1830 indirectly, engage in the following activities:

1831 (A) Encouraging or directing small employers to refrain from filing
1832 an application for coverage with the small employer carrier because of
1833 the health status, claims experience, industry, occupation or
1834 geographic location of the small employer, except the provisions of
1835 this subparagraph shall not apply to information provided by a small
1836 employer carrier or producer to a small employer regarding the
1837 carrier's established geographic service area or a restricted network
1838 provision of a small employer carrier; or

1839 (B) Encouraging or directing small employers to seek coverage from
1840 another carrier because of the health status, claims experience,
1841 industry, occupation or geographic location of the small employer.

1842 ~~[(12)]~~ (4) No small employer carrier shall, directly or indirectly,
1843 enter into any contract, agreement or arrangement with a producer

1844 that provides for or results in the compensation paid to a producer for
1845 the sale of a health benefit plan to be varied because of the health
1846 status, claims experience, industry, occupation or geographic area of
1847 the small employer. A small employer carrier shall provide reasonable
1848 compensation, as provided under the plan of operation of the
1849 program, to a producer, if any, for the sale of a [special or a small
1850 employer] health care plan. No small employer carrier shall terminate,
1851 fail to renew or limit its contract or agreement of representation with a
1852 producer for any reason related to the health status, claims experience,
1853 occupation, or geographic location of the small employers placed by
1854 the producer with the small employer carrier.

1855 [(13)] (5) No small employer carrier or producer shall induce or
1856 otherwise encourage a small employer to separate or otherwise
1857 exclude an employee from health coverage or benefits provided in
1858 connection with the employee's employment.

1859 [(14) Denial by a small employer carrier of an application for
1860 coverage from a small employer shall be in writing and shall state the
1861 reasons for the denial.]

1862 [(15)] (6) No small employer carrier or producer shall disclose (A) to
1863 a small employer the fact that any or all of the eligible employees of
1864 such small employer have been or will be reinsured with the pool, or
1865 (B) to any eligible employee or dependent the fact that he has been or
1866 will be reinsured with the pool.

1867 [(16)] (7) If a small employer carrier enters into a contract,
1868 agreement or other arrangement with another party to provide
1869 administrative, marketing or other services related to the offering of
1870 health benefit plans to small employers in this state, the other party
1871 shall be subject to the provisions of this section.

1872 [(17)] (8) The commissioner may adopt regulations, in accordance
1873 with the provisions of chapter 54, setting forth additional standards to
1874 provide for the fair marketing and broad availability of health benefit
1875 plans to small employers.

1876 [(18) Each small employer carrier shall maintain at its principal
1877 place of business a complete and detailed description of its rating
1878 practices and renewal underwriting practices, including information
1879 and documentation that demonstrates that its rating methods and
1880 practices are based upon commonly accepted actuarial assumptions
1881 and are in accordance with sound actuarial principles. Each small
1882 employer carrier shall file with the commissioner annually, on or
1883 before March fifteenth, an actuarial certification certifying that the
1884 carrier is in compliance with this part and that the rating methods have
1885 been derived using recognized actuarial principles consistent with the
1886 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
1887 shall be in a form and manner and shall contain such information as
1888 determined by the commissioner. A copy of the certification shall be
1889 retained by the small employer carrier at its principal place of
1890 business. Any information and documentation described in this
1891 subdivision but not subject to the filing requirement shall be made
1892 available to the commissioner upon his request. Except in cases of
1893 violations of sections 38a-564 to 38a-573, inclusive, the information
1894 shall be considered proprietary and trade secret information and shall
1895 not be subject to disclosure by the commissioner to persons outside of
1896 the department except as agreed to by the small employer carrier or as
1897 ordered by a court of competent jurisdiction.

1898 (19) The commissioner may suspend all or any part of this section
1899 relating to the premium rates applicable to one or more small
1900 employers for one or more rating periods upon a filing by the small
1901 employer carrier and a finding by the commissioner that either the
1902 suspension is reasonable in light of the financial condition of the
1903 carrier or that the suspension would enhance the efficiency and
1904 fairness of the marketplace for small employer health insurance.

1905 (20) For rating periods commencing prior to July 1, 1995, a small
1906 employer carrier shall quote premium rates to any small employer
1907 within thirty days after receipt by the carrier of such employer's
1908 completed application.]

1909 [(21)] (9) Any violation of subdivisions [(10) to (16)] (3) to (7),
1910 inclusive, of this section and of any regulations established under
1911 subdivision [(17)] (8) of this section shall be an unfair and prohibited
1912 practice under sections 38a-815 to 38a-830, inclusive.

1913 [(22) (A) With respect to plans or arrangements issued pursuant to
1914 subsection (i) of section 5-259, at the option of the Comptroller, the
1915 premium rates charged or offered to small employers purchasing
1916 health insurance shall not be subject to this section, provided (i) the
1917 plan or plans offered or issued cover such small employers as a single
1918 entity and cover not less than three thousand employees on the date
1919 issued, (ii) each small employer is charged or offered the same
1920 premium rate with respect to each employee and dependent, and (iii)
1921 the plan or plans are written on a guaranteed issue basis.

1922 (B) With respect to plans or arrangements issued by an association
1923 group plan, at the option of the administrator of the association group
1924 plan, the premium rates charged or offered to small employers
1925 purchasing health insurance shall not be subject to this section,
1926 provided (i) the plan or plans offered or issued cover such small
1927 employers as a single entity and cover not less than three thousand
1928 employees on the date issued, (ii) each small employer is charged or
1929 offered the same premium rate with respect to each employee and
1930 dependent, and (iii) the plan or plans are written on a guaranteed issue
1931 basis. In addition, such association group (I) shall be a bona fide group
1932 as set forth in the Employee Retirement and Security Act of 1974, (II)
1933 shall not be formed for the purposes of fictitious grouping, as defined
1934 in section 38a-827, and (III) shall not issue any plan that shall cause
1935 undue disruption in the insurance marketplace, as determined by the
1936 commissioner.]

1937 Sec. 20. Subparagraph (C) of subdivision (2) of section 38a-567 of the
1938 general statutes, as amended by section 19 of this act, is repealed and
1939 the following is substituted in lieu thereof (*Effective January 1, 2016*):

1940 (C) (i) With respect to nongrandfathered plans issued to small
1941 employers, the premium rates charged or offered shall be established

1942 on the basis of a single pool of all nongrandfathered plans, adjusted to
1943 reflect one or more of the following classifications:

1944 (I) Age, in accordance with a uniform age rating curve established
1945 by the commissioner;

1946 (II) Geographic area, as defined by the commissioner.

1947 (ii) Total premium rates for family coverage for nongrandfathered
1948 plans shall be determined by adding the premiums for each individual
1949 family member, except that with respect to family members under
1950 twenty-one years of age, the premiums for only the three oldest
1951 covered children shall be taken into account in determining the total
1952 premium rate for such family.

1953 (iii) Premium rates for employees and dependents for
1954 nongrandfathered plans shall be calculated for each covered individual
1955 and premium rates for the small employer group shall be calculated by
1956 totaling the premiums attributable to each covered individual.

1957 (iv) Premium rates for any given plan may vary by (I) actuarially
1958 justified differences in plan design, and (II) actuarially justified
1959 amounts to reflect the policy's provider network and administrative
1960 expense differences that can be reasonably allocated to such policy.

1961 Sec. 21. Section 38a-569 of the general statutes is repealed and the
1962 following is substituted in lieu thereof (*Effective from passage*):

1963 (a) (1) There is established a nonprofit entity to be known as the
1964 "Connecticut Small Employer Health Reinsurance Pool". All insurers
1965 issuing health insurance in this state and insurance arrangements
1966 providing health plan benefits in this state on and after July 1, 1990,
1967 shall be members of the pool.

1968 (2) On or before July 15, 1990, the commissioner shall give notice to
1969 all insurers and insurance arrangements of the time and place for the
1970 initial organizational meeting, which shall take place by September 1,
1971 1990. The members shall select the initial board, subject to approval by

1972 the commissioner. The board shall consist of at least five and not more
1973 than nine representatives of members. There shall be no more than two
1974 members of the board representing any one insurer or insurance
1975 arrangement. In determining voting rights at the organizational
1976 meeting, each member shall be entitled to vote in person or by proxy.
1977 The vote shall be weighted based upon net health insurance premium
1978 derived from this state in the previous calendar year. To the extent
1979 possible, at least one-third of the members of the board shall be
1980 domestic insurance companies and at least two-thirds of the members
1981 of the board shall be small employer carriers. At least one member of
1982 the board shall be a health care center and at least one member shall be
1983 a small employer carrier with less than one hundred million dollars in
1984 net small employer health insurance premium in this state. The
1985 Insurance Commissioner shall be an ex-officio member of the board.
1986 The net premium amount shall be adjusted by the board periodically
1987 for health care cost inflation. In approving selection of the board, the
1988 commissioner shall assure that all members are fairly represented. The
1989 membership of all boards subsequent to the initial board shall, to the
1990 extent possible, reflect the same distribution of representation as is
1991 described in this subdivision.

1992 (3) If the initial board is not elected at the organizational meeting,
1993 the commissioner shall appoint the initial board within fifteen days of
1994 the organizational meeting.

1995 (4) Within ninety days after the appointment of such initial board,
1996 the board shall submit to the commissioner a plan of operation and
1997 thereafter any amendments thereto necessary or suitable to assure the
1998 fair, reasonable and equitable administration of the pool. The
1999 commissioner shall, after notice and hearing, approve the plan of
2000 operation provided he determines it to be suitable to assure the fair,
2001 reasonable and equitable administration of the pool, and provides for
2002 the sharing of pool gains or losses on an equitable proportionate basis
2003 in accordance with the provisions of subsection (d) of this section,
2004 revision of 1958, revised to January 1, 2013. The plan of operation shall
2005 become effective upon approval in writing by the commissioner

2006 consistent with the date on which the coverage under this section shall
2007 be made available. If the board fails to submit a suitable plan of
2008 operation within one hundred eighty days after its appointment, or at
2009 any time thereafter fails to submit suitable amendments to the plan of
2010 operation, the commissioner shall, after notice and hearing, adopt and
2011 promulgate a plan of operation or amendments, as appropriate. The
2012 commissioner shall amend any plan adopted by him, as necessary, at
2013 the time a plan of operation is submitted by the board and approved
2014 by the commissioner.

2015 (5) [The] On and after the effective date of this section, the plan of
2016 operation shall establish procedures for: (A) Handling and accounting
2017 of assets and moneys of the pool, and for an annual fiscal reporting to
2018 the commissioner; (B) filling vacancies on the board, subject to the
2019 approval of the commissioner; (C) selecting an administrator and
2020 setting forth the powers and duties of the administrator; (D) reinsuring
2021 risks; [in accordance with the provisions of this section;] (E) collecting
2022 assessments from all members to provide for claims reinsured by the
2023 pool and for administrative expenses incurred or estimated to be
2024 incurred during the period for which the assessment is made; and (F)
2025 any additional matters at the discretion of the board.

2026 (6) The pool shall have the general powers and authority granted
2027 under the laws of Connecticut to insurance companies licensed to
2028 transact health insurance and, in addition thereto, the specific
2029 authority to: (A) Enter into contracts as are necessary or proper to
2030 carry out the provisions and purposes of this section, including the
2031 authority, with the approval of the commissioner, to enter into
2032 contracts with programs of other states for the joint performance of
2033 common functions, or with persons or other organizations for the
2034 performance of administrative functions; (B) sue or be sued, including
2035 taking any legal actions necessary or proper for recovery of any
2036 assessments for, on behalf of, or against members; (C) take such legal
2037 action as necessary to avoid the payment of improper claims against
2038 the pool; (D) define the array of health coverage products for which
2039 reinsurance will be provided, and to issue reinsurance policies, in

2040 accordance with the requirements of this section; (E) establish rules,
2041 conditions and procedures pertaining to the reinsurance of members'
2042 risks by the pool; (F) establish appropriate rates, rate schedules, rate
2043 adjustments, rate classifications and any other actuarial functions
2044 appropriate to the operation of the pool; (G) assess members in
2045 accordance with the provisions of subsection [(e)] (c) of this section,
2046 and to make advance interim assessments as may be reasonable and
2047 necessary for organizational and interim operating expenses. Any such
2048 interim assessments shall be credited as offsets against any regular
2049 assessments due following the close of the fiscal year; (H) appoint from
2050 among members appropriate legal, actuarial and other committees as
2051 necessary to provide technical assistance in the operation of the pool,
2052 policy and other contract design, and any other function within the
2053 authority of the pool; and (I) borrow money to effect the purposes of
2054 the pool. Any notes or other evidence of indebtedness of the pool not
2055 in default shall be legal investments for insurers and may be carried as
2056 admitted assets.

2057 (b) Any member whose health insurance plan is subject to section
2058 38a-567, as amended by this act, may reinsure with the pool coverage
2059 of an eligible employee of a small employer [,] or any dependent of
2060 such an employee. [, except that no member may reinsure with the
2061 pool coverage of an eligible employee of a small employer, or any
2062 dependent of such an employee, whose premium rates are not subject
2063 to section 38a-567 pursuant to subdivision (22) of section 38a-567. Any
2064 reinsurance placed with the pool from the date of the establishment of
2065 the pool regarding the coverage of an eligible employee of a small
2066 employer, or any dependent of such an employee shall be provided as
2067 follows:]

2068 [(1) (A) With respect to a special health care plan or a small
2069 employer health care plan, the pool shall reinsure the level of coverage
2070 provided; (B) with respect to other plans, the pool shall reinsure the
2071 level of coverage provided up to, but not exceeding, the level of
2072 coverage provided in a small employer health care plan or the
2073 actuarial equivalent thereof as defined and authorized by the board;

2074 and (C) in either case, no reinsurance may be provided in any calendar
2075 year for a reinsured employee or dependent until five thousand dollars
2076 in benefit payments have been made for services provided during that
2077 calendar year for that reinsured employee or dependent, which
2078 payments would have been reimbursed through said reinsurance in
2079 the absence of the annual five-thousand-dollar deductible. The amount
2080 of the deductible shall be periodically reviewed by the board and may
2081 be adjusted for appropriate factors as determined by the board;

2082 (2) With respect to eligible employees, and their dependents,
2083 coverage may be reinsured: (A) Within such period of time after the
2084 commencement of their coverage under the plan as may be authorized
2085 by the board, or (B) commencing January 1, 1992, on the first plan
2086 anniversary after the employer's coverage has been in effect with the
2087 small employer carrier for a period of three years, and every third plan
2088 anniversary thereafter, provided, commencing May 1, 1994,
2089 reinsurance pursuant to this subparagraph shall only be permitted
2090 with respect to eligible employees and their dependents of a small
2091 employer which has no more than two eligible employees as of the
2092 applicable anniversary;

2093 (3) Reinsurance coverage may be terminated for each reinsured
2094 employee or dependent on any plan anniversary;

2095 (4) Reinsurance of newborn dependents shall be allowed only if the
2096 mother of any such dependent is reinsured as of the date of birth of
2097 such child, and all newborn dependents of reinsured persons shall be
2098 automatically reinsured as of their date of birth; and

2099 (5) Notwithstanding the provisions of subparagraph (A) of
2100 subdivision (2) of this subsection: (A) Coverage for eligible employees
2101 and their dependents provided under a group policy covering two or
2102 more small employers shall not be eligible for reinsurance when such
2103 coverage is discontinued and replaced by a group policy of another
2104 carrier covering two or more small employers, unless coverage for
2105 such eligible employees or dependents was reinsured by the prior
2106 carrier; and (B) at the time coverage is assumed for such group by a

2107 succeeding carrier, such carrier shall notify the pool of its intention to
2108 provide coverage for such group and shall identify the employees and
2109 dependents whose coverage will continue to be reinsured. The time
2110 limitations for providing such notice shall be established by the pool.

2111 (c) Except as provided in subsection (d) of this section, premium
2112 rates charged for reinsurance by the pool shall be established at the
2113 following percentages of the rate established by the pool for that
2114 classification or group with similar characteristics and coverage:

2115 (1) One hundred fifty per cent, with respect to all of the eligible
2116 employees, and their dependents, of a small employer, all of whose
2117 coverage is reinsured in accordance with subdivision (2) of subsection
2118 (b) of this section; and

2119 (2) Five hundred per cent, with respect to an eligible employee or
2120 dependent who is individually reinsured in accordance with
2121 subdivision (2) of subsection (b) of this section and is not reinsured
2122 with all eligible employees of an employer and their dependents.

2123 (d) Premium rates charged for reinsurance by the pool to a health
2124 care center which is approved by the Secretary of Health and Human
2125 Services as a health maintenance organization pursuant to 42 USC 300
2126 et seq., and as such is subject to requirements that limit the amount of
2127 risk that may be ceded to the pool, may be modified by the board, if
2128 appropriate, to reflect the portion of risk that may be ceded to the
2129 pool.]

2130 [(e)] (c) (1) Following the close of each fiscal year, the administrator
2131 shall determine the net premiums, the pool expenses of administration
2132 and the incurred losses for the year, taking into account investment
2133 income and other appropriate gains and losses. For purposes of this
2134 section, health insurance premiums earned by insurance arrangements
2135 shall be established by adding paid health losses and administrative
2136 expenses of the insurance arrangement. Health insurance premiums
2137 and benefits paid by a member that are less than an amount
2138 determined by the board to justify the cost of collection shall not be

2139 considered for purposes of determining assessments. For purposes of
2140 this subsection, "net premiums" means health insurance premiums,
2141 less administrative expense allowances.

2142 (2) Any net loss for the year shall be recouped by assessments of
2143 members.

2144 (A) Assessments shall first be apportioned by the board among all
2145 members in proportion to their respective shares of the total health
2146 insurance premiums earned in this state from health insurance plans
2147 and insurance arrangements covering small employers during the
2148 calendar year coinciding with or ending during the fiscal year of the
2149 pool, or on any other equitable basis reflecting coverage of small
2150 employers as may be provided in the plan of operations. An
2151 assessment shall be made pursuant to this subparagraph against a
2152 health care center, [which] that is approved by the Secretary of Health
2153 and Human Services as a health maintenance organization pursuant to
2154 42 USC 300e et seq., subject to an assessment adjustment formula
2155 adopted by the board and approved by the commissioner for such
2156 health care centers [which] that recognizes the restrictions imposed on
2157 such health care centers by federal law. Such adjustment formula shall
2158 be adopted by the board and approved by the commissioner prior to
2159 the first anniversary of the pool's operation.

2160 (B) If such net loss is not recouped before assessments totaling five
2161 per cent of such premiums from plans and arrangements covering
2162 small employers have been collected, additional assessments shall be
2163 apportioned by the board among all members in proportion to their
2164 respective shares of the total health insurance premiums earned in this
2165 state from other individual and group plans and arrangements,
2166 exclusive of any individual Medicare supplement policies as defined in
2167 section 38a-495 during such calendar year.

2168 (C) Notwithstanding the provisions of this subdivision, the
2169 assessments to any one member under subparagraph (A) or (B) of this
2170 subdivision shall not exceed forty per cent of the total assessment
2171 under each subparagraph for the first fiscal year of the pool's operation

2172 and fifty per cent of the total assessment under each subparagraph for
2173 the second fiscal year. Any amounts abated pursuant to this
2174 subparagraph shall be assessed against the other members in a manner
2175 consistent with the basis for assessments set forth in this subdivision.

2176 (3) If assessments exceed actual losses and administrative expenses
2177 of the pool, the excess shall be held at interest and used by the board to
2178 offset future losses or to reduce pool premiums. As used in this
2179 subsection, "future losses" includes reserves for incurred but not
2180 reported claims.

2181 (4) Each member's proportion of participation in the pool shall be
2182 determined annually by the board based on annual statements and
2183 other reports deemed necessary by the board and filed by the member
2184 with it. Insurance arrangements shall report to the board claims
2185 payments made and administrative expenses incurred in this state on
2186 an annual basis on a form prescribed by the commissioner.

2187 (5) Provision shall be made in the plan of operation for the
2188 imposition of an interest penalty for late payment of assessments.

2189 (6) The board may defer, in whole or in part, the assessment of a
2190 health care center if, in the opinion of the board: (A) Payment of the
2191 assessment would endanger the ability of the health care center to
2192 fulfill its contractual obligations, or (B) in accordance with standards
2193 included in the plan of operation, the health care center has written,
2194 and reinsured in their entirety, a disproportionate number of special
2195 health care plans. In the event an assessment against a health care
2196 center is deferred in whole or in part, the amount by which such
2197 assessment is deferred may be assessed against the other members in a
2198 manner consistent with the basis for assessments set forth in this
2199 subsection. The health care center receiving such deferment shall
2200 remain liable to the pool for the amount deferred. The board may
2201 attach appropriate conditions to any such deferment.

2202 [(f) (1) Neither the] (d) (1) The participation in the pool as members,
2203 the establishment of rates, forms or procedures [nor] or any other joint

2204 or collective action required by this section shall not be the basis of any
2205 legal action, criminal or civil liability or penalty against the pool or any
2206 of its members.

2207 (2) Any person or member made a party to any action, suit or
2208 proceeding because the person or member served on the board or on a
2209 committee or was an officer or employee of the pool shall be held
2210 harmless and be indemnified by the program against all liability and
2211 costs, including the amounts of judgments, settlements, fines or
2212 penalties, and expenses and reasonable attorney's fees incurred in
2213 connection with the action, suit or proceeding. The indemnification
2214 shall not be provided on any matter in which the person or member is
2215 finally adjudged in the action, suit or proceeding to have committed a
2216 breach of duty involving gross negligence, dishonesty, wilful
2217 misfeasance or reckless disregard of the responsibilities of office. Costs
2218 and expenses of the indemnification shall be prorated and paid for by
2219 all members. The Insurance Commissioner may retain actuarial
2220 consultants necessary to carry out said commissioner's responsibilities
2221 pursuant to [sections 38a-564 to 38a-572, inclusive] this section, section
2222 38a-564, as amended by this act, 38a-566, as amended by this act, or
2223 38a-567, as amended by this act, and such expenses shall be paid by
2224 the pool established in this section.

2225 Sec. 22. Section 38a-574 of the general statutes is repealed and the
2226 following is substituted in lieu thereof (*Effective from passage*):

2227 (a) [On or before July 1, 1993, the] The board of directors of the
2228 Connecticut Small Employer Health Reinsurance Pool shall establish,
2229 subject to the approval of the Insurance Commissioner, a standard
2230 [underwriting form] family health statement for use by small employer
2231 carriers [for medical underwriting of health insurance plans and
2232 insurance arrangements covering small employers, as defined in
2233 section 38a-564. Within] to determine whether to cede lives to the
2234 reinsurance pool. Not later than ninety days after approval by the
2235 Insurance Commissioner of the [standard underwriting form] family
2236 health statement, the board shall require every small employer carrier,

2237 as a condition of transacting such business in this state, to use the
2238 [form for medical underwriting of] statement for such plans and
2239 arrangements.

2240 (b) The [form] statement may be amended from time to time as the
2241 board deems necessary, subject to the approval of the Insurance
2242 Commissioner.

2243 Sec. 23. Section 38a-543 of the general statutes is repealed and the
2244 following is substituted in lieu thereof (*Effective from passage*):

2245 [No individual, partnership, corporation or unincorporated
2246 association which employs less than twenty employees and provides
2247 group hospital, surgical or medical insurance coverage for its
2248 employees may reduce the coverage provided to any employee or any
2249 employee's spouse solely because he has reached the age of sixty-five
2250 and is eligible for Medicare benefits except to the extent such coverage
2251 is provided by Medicare. The terms of any such plan provided by any
2252 such employer which employs twenty or more employees shall entitle
2253 any employee who has attained the age of sixty-five and any
2254 employee's spouse who has attained the age of sixty-five to group
2255 hospital, surgical or medical insurance coverage under the same
2256 conditions as any covered employee or spouse who is under the age of
2257 sixty-five.] No group health insurance policy delivered, issued for
2258 delivery, renewed, amended or continued in this state shall include
2259 any provision that reduces payments on the basis that an individual is
2260 eligible for Medicare by reason of age, disability or end-stage renal
2261 disease, unless such individual enrolls in Medicare. If such individual
2262 enrolls in Medicare, any such reduction shall be only to the extent such
2263 coverage is provided by Medicare.

2264 Sec. 24. Subsection (f) of section 5-248a of the general statutes is
2265 repealed and the following is substituted in lieu thereof (*Effective from*
2266 *passage*):

2267 (f) [Notwithstanding the provisions of subsection (b) of section 38a-
2268 554, the] The state shall pay for the continuation of health insurance

2269 benefits for the employee during any leave of absence taken pursuant
2270 to this section. In order to continue any other health insurance
2271 coverages during such leave, the employee shall contribute that
2272 portion of the premium the employee would have been required to
2273 contribute had the employee remained an active employee during the
2274 leave period.

2275 Sec. 25. Subsection (i) of section 5-259 of the general statutes is
2276 repealed and the following is substituted in lieu thereof (*Effective from*
2277 *passage*):

2278 (i) The Comptroller may provide for coverage of employees of
2279 municipalities, nonprofit corporations, community action agencies and
2280 small employers and individuals eligible for a health coverage tax
2281 credit, retired members or members of an association for personal care
2282 assistants under the plan or plans procured under subsection (a) of this
2283 section, provided: (1) Participation by each municipality, nonprofit
2284 corporation, community action agency, small employer, eligible
2285 individual, retired member or association for personal care assistants
2286 shall be on a voluntary basis; (2) where an employee organization
2287 represents employees of a municipality, nonprofit corporation,
2288 community action agency or small employer, participation in a plan or
2289 plans to be procured under subsection (a) of this section shall be by
2290 mutual agreement of the municipality, nonprofit corporation,
2291 community action agency or small employer and the employee
2292 organization only and neither party may submit the issue of
2293 participation to binding arbitration except by mutual agreement if
2294 such binding arbitration is available; (3) no group of employees shall
2295 be refused entry into the plan by reason of past or future health care
2296 costs or claim experience; (4) rates paid by the state for its employees
2297 under subsection (a) of this section are not adversely affected by this
2298 subsection; (5) administrative costs to the plan or plans provided
2299 under this subsection shall not be paid by the state; (6) participation in
2300 the plan or plans in an amount determined by the state shall be for the
2301 duration of the period of the plan or plans, or for such other period as
2302 mutually agreed by the municipality, nonprofit corporation,

2303 community action agency, small employer, retired member or
2304 association for personal care assistants and the Comptroller; and (7)
2305 nothing in this section or section 12-202a, 38a-551, as amended by this
2306 act, [38a-553] or 38a-556, as amended by this act, shall be construed as
2307 requiring a participating insurer or health care center to issue
2308 individual policies to individuals eligible for a health coverage tax
2309 credit. The coverage provided under this section may be referred to as
2310 the "Municipal Employee Health Insurance Plan". The Comptroller
2311 may arrange and procure for the employees and eligible individuals
2312 under this subsection health benefit plans that vary from the plan or
2313 plans procured under subsection (a) of this section. Notwithstanding
2314 any provision of part V of chapter 700c, the coverage provided under
2315 this subsection may be offered on either a fully underwritten or risk-
2316 pooled basis at the discretion of the Comptroller. For the purposes of
2317 this subsection, (A) "municipality" means any town, city, borough,
2318 school district, taxing district, fire district, district department of
2319 health, probate district, housing authority, regional work force
2320 development board established under section 31-3k, regional
2321 emergency telecommunications center, tourism district established
2322 under section 32-302, flood commission or authority established by
2323 special act, regional council of governments, transit district formed
2324 under chapter 103a, or the Children's Center established by number
2325 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a
2326 nonprofit corporation organized under 26 USC 501 that has a contract
2327 with the state or receives a portion of its funding from a municipality,
2328 the state or the federal government, or (ii) an organization that is tax
2329 exempt pursuant to 26 USC 501(c)(5); (C) "community action agency"
2330 means a community action agency, as defined in section 17b-885; (D)
2331 "small employer" means a small employer, as defined in
2332 [subparagraph (A) of subdivision (4) of] section 38a-564, as amended
2333 by this act; (E) "eligible individuals" or "individuals eligible for a health
2334 coverage tax credit" means individuals who are eligible for the credit
2335 for health insurance costs under Section 35 of the Internal Revenue
2336 Code of 1986, or any subsequent corresponding internal revenue code
2337 of the United States, as from time to time amended, in accordance with

2338 the Pension Benefit Guaranty Corporation; [and Trade Adjustment
2339 Assistance programs of the Trade Act of 2002 (P.L. 107-210);] (F)
2340 "association for personal care assistants" means an organization
2341 composed of personal care attendants who are employed by recipients
2342 of service (i) under the home-care program for the elderly under
2343 section 17b-342, (ii) under the personal care assistance program under
2344 section 17b-605a, (iii) in an independent living center pursuant to
2345 sections 17b-613 to 17b-615, inclusive, or (iv) under the program for
2346 individuals with acquired brain injury as described in section 17b-
2347 260a; and (G) "retired members" means individuals eligible for a
2348 retirement benefit from the Connecticut municipal employees'
2349 retirement system.

2350 Sec. 26. Subdivision (7) of section 12-201 of the general statutes is
2351 repealed and the following is substituted in lieu thereof (*Effective from*
2352 *passage*):

2353 (7) "Gross direct premiums" means all receipts of premiums from
2354 policyholders and applicants for policies, whether received in the form
2355 of money or other valuable consideration, but excluding annuity
2356 premiums and considerations and premiums received for reinsurances
2357 assumed from other insurance companies; [and premiums received
2358 after July 1, 1990, and before January 1, 1995, for any special health
2359 care plan, as defined in section 38a-564;]

2360 Sec. 27. Subsection (c) of section 12-211 of the general statutes is
2361 repealed and the following is substituted in lieu thereof (*Effective from*
2362 *passage*):

2363 (c) The provisions of this section shall not apply to ad valorem taxes
2364 on real or personal property, personal income taxes, fees for agents'
2365 licenses, special purpose assessments imposed in connection with
2366 particular kinds of insurance including, but not limited to, workers'
2367 compensation assessments and Insurance Guaranty Association Fund
2368 assessments, or to premium taxes on special health care plans as
2369 defined in [section] sections 38a-564, revision of 1958, revised to
2370 January 1, 2013, and 38a-551, as amended by this act, except in the case

2371 where another state or foreign country imposes upon Connecticut
2372 domiciled insurers retaliatory charges for such taxes, fees or
2373 assessments.

2374 Sec. 28. Section 12-212a of the general statutes is repealed and the
2375 following is substituted in lieu thereof (*Effective from passage*):

2376 All corporations organized under sections 38a-199 to 38a-209,
2377 inclusive, and 38a-214 to 38a-225, inclusive, shall pay to the
2378 Commissioner of Revenue Services on or before March first, annually,
2379 a charge at the rate of two per cent of the total net direct subscriber
2380 charges [, excluding those net direct subscriber charges received after
2381 July 1, 1990, and before January 1, 1995, from employers for any special
2382 health care plan, as defined in section 38a-564,] received by such
2383 corporation during the next preceding calendar year, which shall be in
2384 addition to any other payment required under section 38a-48. The
2385 charge required under this section and any other payment required
2386 under said section 38a-48 shall be in compensation for the costs and
2387 expenses of regulation by the Insurance Department and all other
2388 governmental services. The provisions of this chapter pertaining to the
2389 filing of returns, declarations, assessment and collection of taxes, and
2390 penalties imposed on domestic insurance companies shall apply with
2391 respect to the charge imposed under this section, provided
2392 corporations subject to the charge imposed under this section shall not
2393 be subject to any tax imposed under this chapter.

2394 Sec. 29. Subsection (e) of section 17b-265 of the general statutes is
2395 repealed and the following is substituted in lieu thereof (*Effective from*
2396 *passage*):

2397 (e) [Notwithstanding the provisions of subsection (c) of section 38a-
2398 553, no] No self-insured plan, group health plan, as defined in Section
2399 607(1) of the Employee Retirement Income Security Act of 1974, service
2400 benefit plan, managed care plan, or any plan offered or administered
2401 by a health care center, pharmacy benefit manager, dental benefit
2402 manager, third-party administrator or other party that is, by statute,
2403 contract or agreement, legally responsible for payment of a claim for a

2404 health care item or service, shall contain any provision that has the
2405 effect of denying or limiting enrollment benefits or excluding coverage
2406 because services are rendered to an insured or beneficiary who is
2407 eligible for or who received medical assistance under this chapter. No
2408 insurer, as defined in section 38a-497a, shall impose requirements on
2409 the state Medicaid agency, which has been assigned the rights of an
2410 individual eligible for Medicaid and covered for health benefits from
2411 an insurer, that differ from requirements applicable to an agent or
2412 assignee of another individual so covered.

2413 Sec. 30. Subsection (c) of section 17b-284 of the general statutes is
2414 repealed and the following is substituted in lieu thereof (*Effective from*
2415 *passage*):

2416 (c) The commissioner may pay under the Medicaid program, within
2417 available appropriations, the premiums for continued health insurance
2418 coverage under an employer's group health insurance plan, pursuant
2419 to section [38a-554] 38a-512a, as amended by this act, for chronically ill
2420 and disabled persons who are no longer employed and would
2421 otherwise be eligible for Medicaid.

2422 Sec. 31. Subdivision (6) of subsection (c) of section 17b-299 of the
2423 general statutes is repealed and the following is substituted in lieu
2424 thereof (*Effective from passage*):

2425 (6) Expiration of the continuation of coverage periods set forth in
2426 section [38a-554] 38a-512a, as amended by this act;

2427 Sec. 32. Subsection (b) of section 17b-611 of the general statutes is
2428 repealed and the following is substituted in lieu thereof (*Effective from*
2429 *passage*):

2430 (b) The contract shall provide the same benefits as are provided
2431 under contracts issued pursuant to sections 38a-505, as amended by
2432 this act, 38a-546, 38a-551, as amended by this act, and 38a-556 to 38a-
2433 559, inclusive, as amended by this act, except mental and nervous
2434 disorders shall be covered in accordance with section 38a-514.

2435 Sec. 33. Subsection (b) of section 19a-7b of the general statutes is
2436 repealed and the following is substituted in lieu thereof (*Effective from*
2437 *passage*):

2438 (b) The commission shall develop the design, administrative,
2439 actuarial and financing details of program initiatives necessary to
2440 attain the goal described in section 19a-7a. [The commission shall
2441 study the experience of the state under the programs and policies
2442 developed pursuant to sections 12-201, 12-211, 12-212a, 17b-277, 17b-
2443 282 to 17b-284, inclusive, 17b-611, 19a-7a to 19a-7d, inclusive,
2444 subsection (a) of 19a-59b, subsection (b) of section 38a-552, subsection
2445 (d) of section 38a-556 and sections 38a-564 to 38a-573, inclusive, and
2446 shall make interim reports to the General Assembly on its findings by
2447 January 15, 1991, and by February 1, 1992, and a final report on such
2448 findings by February 1, 1993.] The commission shall make
2449 recommendations to the General Assembly on any legislation
2450 necessary to further the attainment of the goal described in section 19a-
2451 7a.

2452 Sec. 34. Subsection (a) of section 31-51o of the general statutes is
2453 repealed and the following is substituted in lieu thereof (*Effective from*
2454 *passage*):

2455 (a) Whenever a relocation or closing of a covered establishment
2456 occurs, the employer of the covered establishment shall pay in full for
2457 the continuation of existing group health insurance, no matter where
2458 the group policy was written, issued or delivered, for each affected
2459 employee and his dependents, if covered under the group policy, from
2460 the date of relocation or closing for a period of one hundred twenty
2461 days or until such time as the employee becomes eligible for other
2462 group coverage, whichever is the lesser, provided any right of such
2463 employee and his dependents to a continuation of coverage, as
2464 required by section [38a-538 or 38a-554] 38a-512a, as amended by this
2465 act, shall not be affected by the provisions of this section, and provided
2466 further the period of continued coverage required by said sections
2467 shall not commence until the period of continued coverage established

2468 by this section has terminated.

2469 Sec. 35. Section 38a-472d of the general statutes is repealed and the
2470 following is substituted in lieu thereof (*Effective from passage*):

2471 (a) Not later than January 1, 2006, the Insurance Commissioner, in
2472 consultation with the Commissioner of Social Services and the
2473 Healthcare Advocate, shall develop a comprehensive public education
2474 outreach program to educate health insurance consumers about the
2475 availability and general eligibility requirements of various health
2476 insurance options in this state. The program shall maximize public
2477 information concerning health insurance options in this state and shall
2478 provide for the dissemination of such information on the Insurance
2479 Department's Internet web site.

2480 (b) The information on the department's Internet web site shall
2481 reference the availability and general eligibility requirements of (1)
2482 programs administered by the Department of Social Services,
2483 including, but not limited to, the Medicaid program and the HUSKY
2484 Plan, Part A and Part B, (2) health insurance coverage provided by the
2485 Comptroller under subsection (i) of section 5-259, as amended by this
2486 act, [(3) health insurance coverage available under comprehensive
2487 health care plans issued pursuant to part IV of this chapter, and (4)]
2488 and (3) other health insurance coverage offered through local, state or
2489 federal agencies or through entities licensed in this state. The
2490 commissioner shall update the information on the web site at least
2491 quarterly.

2492 Sec. 36. Subsection (b) of section 38a-480 of the general statutes is
2493 repealed and the following is substituted in lieu thereof (*Effective from*
2494 *passage*):

2495 (b) [The] Except as otherwise provided in this title, the provisions of
2496 sections 38a-481 to 38a-488, inclusive, as amended by this act, 38a-492,
2497 38a-502 and 38a-505, as amended by this act, shall not apply to any
2498 subscriber contract issued by a health care center.

2499 Sec. 37. Section 38a-573 of the general statutes is repealed and the
2500 following is substituted in lieu thereof (*Effective from passage*):

2501 If any provision of [sections] section 38a-564, as amended by this
2502 act, [to 38a-572, inclusive] 38a-566, as amended by this act, 38a-567, as
2503 amended by this act or 38a-569, as amended by this act, is held invalid,
2504 the invalidity shall not affect other provisions of said sections [which]
2505 that can be given effect without the invalid provisions.

2506 Sec. 38. Sections 38a-538, 38a-553 to 38a-555, inclusive, 38a-565, 38a-
2507 568 and 38a-570 to 38a-572, inclusive, of the general statutes are
2508 repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	38a-183(a)
Sec. 2	<i>from passage</i>	38a-199
Sec. 3	<i>from passage</i>	38a-208
Sec. 4	<i>from passage</i>	38a-214
Sec. 5	<i>from passage</i>	38a-218
Sec. 6	<i>from passage</i>	38a-481
Sec. 7	<i>from passage</i>	38a-513(a) and (b)
Sec. 8	<i>from passage</i>	38a-476
Sec. 9	<i>from passage</i>	38a-478g(a)
Sec. 10	<i>from passage</i>	38a-505
Sec. 11	<i>from passage</i>	38a-512a
Sec. 12	<i>from passage</i>	38a-537
Sec. 13	<i>from passage</i>	38a-551
Sec. 14	<i>from passage</i>	38a-552
Sec. 15	<i>from passage</i>	38a-556
Sec. 16	<i>from passage</i>	38a-557
Sec. 17	<i>from passage</i>	38a-564
Sec. 18	<i>from passage</i>	38a-566
Sec. 19	<i>from passage</i>	38a-567
Sec. 20	<i>January 1, 2016</i>	38a-567(2)(C)
Sec. 21	<i>from passage</i>	38a-569
Sec. 22	<i>from passage</i>	38a-574
Sec. 23	<i>from passage</i>	38a-543
Sec. 24	<i>from passage</i>	5-248a(f)

Sec. 25	<i>from passage</i>	5-259(i)
Sec. 26	<i>from passage</i>	12-201(7)
Sec. 27	<i>from passage</i>	12-211(c)
Sec. 28	<i>from passage</i>	12-212a
Sec. 29	<i>from passage</i>	17b-265(e)
Sec. 30	<i>from passage</i>	17b-284(c)
Sec. 31	<i>from passage</i>	17b-299(c)(6)
Sec. 32	<i>from passage</i>	17b-611(b)
Sec. 33	<i>from passage</i>	19a-7b(b)
Sec. 34	<i>from passage</i>	31-51o(a)
Sec. 35	<i>from passage</i>	38a-472d
Sec. 36	<i>from passage</i>	38a-480(b)
Sec. 37	<i>from passage</i>	38a-573
Sec. 38	<i>from passage</i>	Repealer section

Statement of Legislative Commissioners:

In Secs. 2(b) and 4(b), the reference to subdivision (2) of this subsection was changed to a reference to subdivision (1) of this subsection for accuracy.

INS *Joint Favorable Subst. -LCO*

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 numerous revisions to the health insurance statutes. As these changes concern aspects of private insurance coverage and filings, there is no state or municipal fiscal impact.

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

OLR Bill Analysis**sSB 1023*****AN ACT CONCERNING REVISIONS TO THE HEALTH INSURANCE STATUTES.*****SUMMARY:**

This bill makes numerous changes in the insurance statutes. It requires health insurers 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 unless the commissioner approves the rates (§7). By law, the commissioner already must review and approve rates for individual health insurance policies, HMO contracts, and hospital and medical service corporation contracts.

The bill requires insurers, HMOs, and hospital and medical service corporations to include in their rate filings an actuarial memorandum, including pricing assumptions, claims experience, and premium rates and loss ratios from the policy's or contract's inception (§§ 1, 3, 5, & 7). It defines "loss ratio" as the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations.

The bill also prohibits individual and group health insurance policies from reducing a person's coverage because he or she is eligible for Medicare due to age, disability, or end-stage renal disease (§§ 6 & 23). It allows a coverage reduction when a person is actually enrolled in Medicare, but only to the extent Medicare provides coverage. Current law prohibits group health insurance policies issued to employers with (1) fewer than 20 employees from reducing coverage when a person, because of age, is eligible for but not enrolled in Medicare and (2) 20 or more employees from discriminating against a person in terms of benefits because he or she turned age 65.

Additionally, the bill makes numerous changes in the insurance statutes to conform state law to the federal Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, as amended). It redefines “small employer” to mean, as of January 1, 2016, an employer with between one and 100 employees, not including a sole proprietor (§ 17). Current law defines it as an employer with one to 50 employees, including a self-employed person. The bill also:

1. expands the prohibition on preexisting condition provisions, which limit or exclude benefits because a person had a health condition before coverage was effective (§ 8);
2. requires insurers, HMOs, and similar entities (“entities”) to make individual and small employer group health insurance policies and contracts available on a guaranteed issue basis (i.e., the entity must accept every applicant) (§§ 6 & 19);
3. eliminates a requirement for entities to 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 (§§ 9-12);
4. prohibits entities from using gender, industry, and group size as rating factors for small employer group health insurance policies (§ 19);
5. allows entities to use (a) provider networks and administrative expenses as rating factors for individual and small employer group health insurance policies and (b) tobacco use as a rating factor for individual health insurance policies (§§ 6, 19, & 20);
6. requires small employer group health insurance policies to provide a special enrollment period for certain eligible employees and dependents, similar to current law for late enrollees (§ 19); and
7. eliminates requirements that insurers, the Health Reinsurance

Association (HRA), and the Connecticut Small Employer Health Reinsurance Pool (CSHERP) offer certain statutory benefit plans (§§ 13-17, 21-22, & 38).

Lastly, the bill eliminates obsolete provisions and makes other minor, technical, and conforming changes (§§ 24-38)

EFFECTIVE DATE: Upon passage, except for a provision that allows insurers to vary premium rates for certain small employer health insurance policies to reflect the policies' different provider networks and administrative expenses (§ 20), which is effective January 1, 2016.

§ 8 – PREEXISTING CONDITION PROVISIONS

The bill broadens the prohibition on the use of preexisting condition provisions. It 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 anyone, including adults. The law already prohibits preexisting condition provisions for children under age 19. Current law allows preexisting condition provisions for adults that do not 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.

§§ 6, 19, & 20 – RATING HEALTH INSURANCE POLICIES

Grandfathered and Non-grandfathered Plans

The bill distinguishes between grandfathered and non-grandfathered plans with regard to permissible rating practices for individual and small employer group health insurance policies or plans. A “grandfathered plan” is a health insurance policy or plan that was in existence on March 23, 2010 (before the ACA took effect) and has not been changed in ways that substantially reduce benefits or increase costs for consumers.

Individual Rating

The bill sets out rating provisions for individual health insurance policies or plans written by insurers, HMOs, and hospital and medical service corporations. It specifies that health insurance issued to an association or other insurance arrangement that is not made up solely of employer groups must be treated as individual health insurance.

Under the bill, grandfathered individual health insurance policies and plans must be community rated (i.e., the premium rates offered or charged must be set based on a single pool of all grandfathered plans).

The bill requires non-grandfathered individual health insurance policies and plans to be rated using modified community rating. Thus, premiums offered or charged must be set based on a single pool of all non-grandfathered plans, but may then be adjusted to reflect the covered person's age, geographic area, and tobacco use. A rate factoring in tobacco use may not vary by a ratio of more than 1.5 to 1.0 and may only be applied with respect to people who may legally use tobacco. "Tobacco use" means using tobacco four or more times a week on average within the preceding six-month period, but excludes religious or ceremonial use.

Under the bill, 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 children may be added.

The bill permits premium rates for grandfathered or non-grandfathered plans to vary based on actuarially justified amounts to reflect differences in the plans' benefit designs, provider networks, and administrative expenses.

Small Employer Rating

The bill sets out rating provisions for small employer group health insurance policies or plans written by insurers, HMOs, and hospital and medical service corporations (entities). It specifies that associations of small employers, as well as health insurance plans and other

arrangements covering small employers are subject to its provisions.

The bill retains current law with respect to rating grandfathered plans. Thus, it allows the entities to charge rates for grandfathered small employer group plans that are based on a community rate (i.e., single pool of grandfathered plans) and adjusted to reflect various classifications, including age, gender, geographic area, industry, group size, family composition, and administrative savings for certain associations.

For non-grandfathered plans, the bill eliminates gender, industry, group size, and administrative cost savings as permissible rating factors. Upon passage, the bill allows rates for non-grandfathered small employer group plans to be based on a community rate (i.e., single pool of non-grandfathered plans) and adjusted to reflect only age, geographic area, and plan design. Beginning January 1, 2016, it also allows the rates to vary by actuarially justified amounts to reflect the plan's provider network and administrative expense differences.

Under the bill:

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 children may be added and
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.

§ 19 – SPECIAL ENROLLMENT PERIOD

The bill requires small employer group 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.

§§ 13-17, 21-22, & 38 – 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 employer 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.

BACKGROUND

Related Bill

sSB 9, reported favorably by the Insurance and Real Estate Committee, requires health insurers to file rates for group health insurance policies with the insurance commissioner for approval. It establishes a specific rate approval process for individual and small employer group health insurance policies, under which the commissioner must hold up to four hearings a year if certain criteria are met. It defines "small employer" as an employer with 50 or fewer employees.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 16 Nay 2 (03/17/2015)