REGS-1 Rev. 09/2013
(Title page)

For permanent regulations
First NOTICED ON AND AFTER JULY 1, 2013

IMPORTANT: Use this form (**REGS-1**) to submit permanent regulations to the Legislative Regulation Review Committee.
For ***emergency regulations*, use form REGS-1-E instead.**
For *non-substantive technical amendments and repeals* proposed without prior notice or hearing as permitted by subsection (g) of CGS 4-168, as amended by PA 13-247 and PA 13-274, use form REGS-1-T instead.

Please read the additional instructions on the back of the last page (Certification Page) before completing this form. Failure to comply with the instructions may cause disapproval of proposed regulations.

State of Connecticut

REGULATION

of the

NAME OF AGENCY:

INSURANCE DEPARTMENT

Concerning

SUBJECT MATTER OF REGULATION:

CONDITIONS FOR APPROVAL TO PARTICIPATE
IN THE CONNECTICUT PARTNERSHIP FOR LONG TERM CARE

Section 38a-475-4 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-475-4. Conditions for partnership-approval

(a) No long-term care insurance policy shall be advertised, solicited, or issued for delivery in this state as a partnership-approved long-term care policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) The following standards apply to partnership-approved long-term care policies as defined herein and are in addition to all other requirements of sections 38a-475-1 to 38a-475-6, inclusive, of the [r]Regulations of Connecticut [s]State [a]Agencies.

(c) Each company seeking partnership-approval for a long-term care insurance product shall:
(1) Notify the Insurance Department in writing that it will provide to the consumer, prior to any application for a partnership-approved policy, a complete description of the Connecticut Partnership for Long-Term Care as prepared by the Office [Of]of Policy and Management, including the Connecticut partnership's toll free phone number, and an outline of coverage.

(2) Offer the option of or include a provision for Home and Community-Based Services, with a minimum benefit of one (1) year at issue, in addition to nursing home care.
All home care plans shall include case management services delivered by an access agency. Case management services shall include, but need not be limited to, the development of a comprehensive individualized assessment and plan of care and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

(3) Provide a provision for inflation protection which satisfies at least one of the following criteria:

(A) The policy covers at least [70]seventy (70) percent of the actual charges or at least [70]seventy (70) percent of the average Connecticut private pay rate, without increases in premium, for that service based on a listing of average private pay rates that will be inflated or updated annually by the Office of Policy and Management and does not include a maximum specified daily indemnity amount or daily limit. The policy shall also provide for increases in lifetime benefit levels, without related increases in premium, at a rate not less than [five] three and one half (3.5) percent each year over the previous year for each year the contract is in force except that, at the option of the insurer, policyholders and applicants [65] sixty-five (65) years of age and older may be given the option not to inflate their lifetime benefit levels. Premiums shall be based on the age of the policyholder at the time of the issuance of the partnership-approved policy; or

(B) The policy provides for automatic increases in the per diem dollar level, without related increases in premiums at a rate not less than [five] three and one half (3.5) percent each year over the previous year for each year the contract is in force. The policy shall also provide for increases in lifetime benefit levels, without related increases in premium, at a rate not less than [five] three and one half (3.5) percent each year over the previous year for each year the contract is in force except that, at the option of the insurer, policyholders and applicants [65] sixty-five (65) years of age and older may be given the option not to inflate their lifetime benefit levels. Premiums shall be based on the age of the policyholder at the time of the issuance of the partnership-approved policy.

(4) At a minimum, provide a nursing home benefit of at least [$167.00] $235.00 a day for policies applied for in [2007] 2014. For each year after [2007] 2014, the minimum daily nursing home benefit shall be [5%] three and one half (3.5) percent greater than the previous year's minimum, rounded up to the nearest dollar amount. No policy shall pay for care in excess of the actual charges.

In addition, those policies issued with home and community-based services shall provide a daily home and community-based benefit that, at a minimum, equals at least [50]fifty (50) percent of the minimum daily nursing home benefit in effect for any given year. No policy shall pay for care in excess of the actual charges.

Policies that pay benefits based on a percentage of costs, and not a daily benefit amount, shall provide benefits which are equal to at least [70%]seventy (70) percent of the actual charges incurred by the insured or at least [70%]seventy (70) percent of the average private pay rate provided by the Office of Policy and Management for each service.

(5) Use applications to be signed by the applicant acknowledging:

(A) That the agent delivered to the applicant at time of application, a copy of "Before You Buy," the state's toll-free number for consumer assistance, a graphic comparison of inflating vs. fixed benefits and premiums, and a "Notice to Applicants Regarding Mandatory Inflation Protection." The following disclosure statement shall be used (or in substantially similar language).

I acknowledge that I have received a copy of "Before You Buy," a complete description of the Connecticut Partnership for Long-Term Care, prepared by the State of Connecticut, including the state's toll-free number, 1-800-547-3443. I have also been advised that I can request individual consumer information assistance from the State of Connecticut. I have also received a graphic comparison of inflating vs. fixed benefits and premiums and the "Notice To Applicant Regarding Mandatory Inflation Protection."

_____ _____

Signature of Applicant(s) Date

(B) That the applicant agrees to the release of information by the insurer to the State of Connecticut as may be needed to evaluate the Connecticut Partnership for Long-Term Care, document a claim for Medicaid asset protection and meet Medicaid audit requirements. [said] Said release shall be in the following format and require a separate signature by the applicant(s):

I hereby agree to the release of my insurance records pertaining to this long-term care insurance policy (certificate) by the (insert insurance company name) to the State of Connecticut for the purpose of documenting a claim for Asset Protection under the Connecticut Medicaid program, evaluating the Connecticut Partnership for Long-Term Care, and meeting Medicaid audit requirements. I understand that my records will be used for no purpose other than those stated above, and will be kept strictly confidential by the State of Connecticut.

_____ _____

(Signature of Applicant(s)) Date

(C) That the agent delivered to the applicant at the time of application a description regarding mandatory inflation protection that shall be in the following format:

NOTICE TO APPLICANT REGARDING MANDATORY INFLATION PROTECTION

In order for this long-term care policy (certificate) to remain partnership-approved by the State of Connecticut and qualify to provide Asset Protection for the State Medicaid program in Connecticut, daily coverage benefits shall meet or exceed standards established by the State of Connecticut. The insurance company will provide you with a graphic comparison showing the differences in premiums and benefits, over at least a twenty (20) year period, between a policy that increases benefits and a policy that does not increase benefits. Failure to maintain the required daily coverage benefits will result in the policy losing its partnership-approved status and no longer being allowed to provide Asset Protection. It is the insurance company's responsibility to automatically inflate daily coverage benefit levels in order to maintain partnership-approval; it is your responsibility to make premium payments in order to maintain coverage and eligibility for Asset Protection.

(D) That the agent delivered to the applicant at the time of application a graphic comparison showing the differences in premiums and benefits, over at least a twenty (20) year period, between a policy that increases benefits and a policy that does not increase benefits.

(6) Report all sales involving replacement to the Commissioner within thirty (30) days of the effective date of the newly issued policy or certificate. The report shall include the name and address of the insured, the name of the company whose policy is being replaced and the name of the agent replacing the coverage. For sales involving replacement by an insurer other than a direct response insurer, this report shall also include a comparison of the coverage issued with that being replaced, including a comparison of the premiums and an explanation of how said replacement was beneficial to the insured.

(7) Issue a policy which shall include a provision which allows for a thirty (30) day period within which coverage may be cancelled by the applicant by delivering or mailing the evidence of coverage to the insurer or the agent through whom it was effected for a full refund of any premium that was paid. The policy shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate to the insurer or its agent for cancellation within thirty (30) days of

its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured is not satisfied for any reason.

(8) Agree to provide to each individual who is denied a partnership-approved long term care insurance policy, a survey produced by the Office of Policy and Management which the individual would, at his or her option, complete and return to the Office of Policy and Management.

(9) Issue a policy which does not require prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

(10) Provide assurances to the Commissioner that no agent will be authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing a partnership-approved long-term care insurance policy unless the agent has completed, seven (7) hours of training on long term care insurance in general and the Connecticut Partnership for Long-Term Care specifically. Such assurances shall be in the form of a document signed by [[the agent and]] a representative of the company attesting to the completion of the required training by the agent and submitted to the Commissioner. All training programs designed to meet the requirements of this subdivision shall receive prior approval from the Office of Policy and Management.

(11) Issue a policy which, in the event the policy is about to lapse, proactively offers, as defined in this subdivision, the insured the option to switch their coverage to a lower lifetime maximum benefit. The offering shall provide the policyholder the option of reducing their lifetime maximum benefit to any lifetime maximum benefit available from the insurer. The offering shall include, at a minimum, an option covering a period of care less than or equal to two (2) years. After the policy has been in force for at least one (1) year, this option need only be offered one time. Premiums shall be based on the age of the policyholder at the time of the issuance of the original partnership-approved policy and shall be less than the premium the policyholder had been charged prior to electing the lower lifetime maximum benefit. Except for the premium and lifetime maximum benefit, all other provisions and benefits that were part of the policy at the time the lifetime maximum benefit was changed shall remain in force. For purposes of this subdivision, proactively offering the lower lifetime maximum benefit means, at a minimum, sending a letter to the policyholder explaining the option to switch coverage to a lower amount, while providing no less than[15] fifteen (15) days for the policyholder to switch their coverage before their policy lapses, except in a case where:

(A) The balance of the original policy's available benefits (after any claims have been paid) would provide for the equivalent of one (1) year of coverage or less; or
(B) The original policy was issued with the equivalent of one (1) year of coverage.

(12) Issue a policy which in the event a policyholder lapses a partnership-approved policy and retains a non-forfeiture benefit, the policy will maintain its partnership-[ ]approval status only so long as the partnership-approved policy's non-forfeiture benefit will pay benefits. A non-forfeiture benefit that returns premium to the policyholder will result in the policy losing its partnership-approval once the return of premium non-forfeiture benefit is accessed.

(13) Issue a policy which defines "One period of confinement" as meaning consecutive days of confinement: it shall be deemed to include successive periods of confinement which are due to the same or related cause and are not separated by at least ninety (90) days during which the insured is not confined for either skilled nursing care, custodial, intermediate care, or home and community-based care.

(14) Issue a policy that makes maximum benefits available in dollars and not in days of care. Nothing in this subsection shall prevent an insurance company from expressing its maximum benefits as days of care when marketing their partnership-approved policies as long as the actual payment of benefits is based on dollars and not days of care.

(15) Issue a policy that provides for one pool of benefit dollars when home and community-based services are chosen in addition to nursing home benefits. The one pool of benefit dollars will be available to the insured to cover any of the benefits covered under the policy.

(16) Issue a policy that does not limit payments to the room and board charges in an institution, such as a nursing home, as long as the payments do not exceed the daily maximum benefit or the actual charges.

(17) Issue a policy that includes a description of Medicaid asset protection and Connecticut Partnership for Long-Term Care residency requirements in the policy and outline of coverage. The plan of action requirements will include the format and language to be used for the description.

(18) Issue a policy that includes licensed homemaker-home health aide agencies as an eligible provider in the policy and certificate.

(19) Offer a policy that provides for automatic increases in the per diem dollar and lifetime benefit levels, without related increases in premiums, at a rate of five (5) percent each year over the previous year for each year the policy is in force.

(d) Long-term care insurance policies that qualify for partnership-approval will be required to include a statement on the front page of the policy and on the outline of coverage in bold type and in contrasting color to the effect that the policy has been partnership-approved and provides Medicaid asset protection under the Connecticut Partnership for Long-Term Care. Long-term care insurance policies that qualify for partnership-approval shall utilize the Connecticut Partnership for Long-Term Care logo on partnership-approved policies, outlines of coverage and applications in a manner prescribed by the Office of Policy and Management. Conversely, long-term care insurance policies that are not partnership-approved shall include a statement on the front page of the policy in bold type and in contrasting color to the effect that the policy does not qualify for Medicaid asset protection. Such statement shall be as follows: "This Policy Does Not Qualify For Medicaid Asset Protection."

(e) Long-term care insurance policies in force may be amended to qualify for partnership-approval by fulfilling all partnership-approval requirements.

(f) A policyholder who has had his or her premium increased by at least fifty (50) percent over the life of the policy shall be able to retain his or her partnership-approved policy without such policy being subject to the provisions of subsection (c)(3) or (c)(4) of this section, provided some level of inflation protection for benefits, without related increases in premium, is included in the policy.

Statement of Purpose

Pursuant to CGS Section 4-170(b)(3), "Each proposed regulation shall have a statement of its purpose following the final section of the regulation." Enter the statement here.

The purpose of these amendments is to set forth conditions for an insurer to participate in The Connecticut Long Term Care Partnership initiative.

A. The problems, issues or circumstances that the regulation proposes to address.
Parameters for increases in premium and consequent effects on coverage required clarification.

B. Summary of the main provisions of the regulation.
The amendments describe limits on premium increases and increases in benefit levels.

C. The legal effect of the regulation, including all ways that the regulation would change existing regulations or other laws.

The amendments will not affect other laws or regulations.