



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

AUGUST 31, 2007

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

RE: NOTICE OF NEW OR MODIFIED BENEFITS REQUIRED TO BE PROVIDED

The legislature enacted several new laws that impact group and individual health insurance policies delivered or issued for delivery in Connecticut. All entities are reminded that all policy forms are subject to prior approval. Policies are reviewed in the order of date received by the Insurance Department. For policy forms that are already approved, you are asked to file an endorsement or amendatory rider to be attached to the approved policy in order to expedite the review process. Entities should file a red lined version as well as two clean copies along with a postage paid envelope of sufficient size to receive a stamped copy.

PA 07-28 An Act Concerning Nonforfeiture Requirements with Respect to Long-term Care Policies

This act requires that a non-forfeiture benefit option be offered at the time of solicitation or application of an individual long-term care policy. If this option is declined, the policy must provide for a contingent benefit upon lapse available for a specified time following a substantial increase in premium rates. This change is effective July 1, 2008.

PA 07-96 An Act Regulating Limited Benefit Medical Plans

This act defines limited coverage to be a policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that contains an annual maximum benefit of less than one hundred thousand dollars or a per service or per condition benefit limit of less than twenty thousand dollars. A comprehensive policy with inside limits per service of less than twenty thousand dollars is not interpreted to fall under this definition. All policies and certificates that provide limited coverage delivered or issued for delivery in this state on or after January 1, 2008 are required to contain the following disclosure:

“THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF

THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS FOLLOW:
(INSURER TO SPECIFY SUCH AMOUNTS).”

PA 07-113 An Act Concerning Postclaims Underwriting

No individual health insurance plan or insurance arrangement may impose a preexisting conditions provision which excludes coverage beyond twelve months following the insured’s effective date of coverage. Any preexisting conditions provision may only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

No short-term health insurance policy issued on a nonrenewable basis for six months or less may impose a preexisting conditions provision that excludes coverage beyond twelve months following the insured’s effective date of coverage. Any preexisting conditions provision may only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the twenty-four months immediately preceding the effective date of coverage. Any policy, application or sales brochure issued for such short-term health insurance policy that imposes such preexisting conditions provision shall disclose in a conspicuous manner in not less than fourteen-point bold face type the following statement:

“THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.”

In the event an insurer or health care center issues two or more consecutive short-term health insurance policies on a nonrenewable basis for six months or less which imposes a preexisting conditions provision to the same individual, the insurer or health care center shall reduce the preexisting conditions exclusion period in the subsequent policies by the cumulative period of time such individual was covered under prior policies.

PA 07-197 An Act Expanding Insurance Coverage for Specialized Formulas for Children

All individual and group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery or renewed in this state on or after October 1, 2007, shall provide coverage for specialized formulas for children up to age twelve when such specialized formulas are medically necessary for the treatment of a disease or condition and are administered under the direction of a physician.

PA 07-226 An Act Establishing a Long-term Care Initiative

Effective October 1, 2007, a long-term care policy may have an elimination period over one hundred days, but not to exceed two years of confinement provided such period is covered by an irrevocable trust in an amount estimated to be sufficient to furnish coverage to the grantor of the trust for the duration of the elimination period. Such trust shall create an unconditional duty to pay the full amount held in trust exclusively to cover the costs of confinement during the elimination period, subject only to taxes and any trustee’s charges allowed by law. Payment shall be made directly to the provider. The duty of the trustee may be enforced by the state, the grantor or any person acting on behalf of the grantor.

Rate filings shall be required to include the factors and methodology used to estimate irrevocable trust values if the policy filed with the Insurance Department includes an option for an elimination period in excess of one hundred days.

PA 07-2 of the June Special Session, An Act Implementing the Provisions of the Budget Concerning Human Services and Public Health (Sections 51, 52, 64, 65)

All individual health policies of the type specified in subdivisions (1), (2), (4), (11) and (12) of subsection 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2009 shall provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to the following subsection of this act:

Sec. 48. (NEW) (*Effective January 1, 2009*) (a) Each primary care provider giving pediatric care in this state, excluding a hospital emergency department and its staff: (1) Shall conduct lead screening at least annually for each child nine to thirty-five months of age, inclusive, in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut; (2) shall conduct lead screening for any child thirty-six to seventy-two months of age, inclusive, who has not been previously screened or for any child under seventy-two months of age, if clinically indicated as determined by the primary care provider in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut; (3) shall conduct a medical risk assessment at least annually for each child thirty-six to seventy-one months of age, inclusive, in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut; (4) may conduct a medical risk assessment at any time for any child thirty-six months of age or younger who is determined by the primary care provider to be in need of such risk assessment in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee Recommendations for Childhood Lead Screening in Connecticut.

(b) The requirements of this section do not apply to any child whose parents or guardians object to blood testing as being in conflict with their religious tenets and practice.

On or after January 1, 2009, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of subsection 38a-469 of the general statutes shall provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to section 48 of this act, stated above.

All individual health policies of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of subsection 38a-469 of the general statutes delivered, issued for delivery, amended or renewed in this state on or after January 1, 2009, shall provide that coverage for a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first: the date on which the child marries, or attains the age of twenty six as long as the child is a resident of the state except for full-time attendance at an out-of-state accredited institution of higher education or resides out of state with a custodial parent pursuant to a child custody determination as defined in 46b-115a.

All group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed or continued in this state on or after January 1, 2009 shall provide the option for a covered child to

continue coverage for the longer of the following periods: At the end of the month following the month in which the child marries, or attains the age of twenty-six, provided the child is a resident of the state except for full-time attendance at an out-of-state accredited institution of higher education or resides out of state with a custodial parent pursuant to a child custody determination, as defined in section 46b-115a.

PA 07-252 An Act Concerning Revisions to Statutes Relating to the Departments of Public Health and Social Services and Town Clerks (Sections 70, 71)

All individual and group health policies delivered, issued for delivery, renewed, amended or continued in the state on or after July 12, 2007, shall provide benefits for isolation care and emergency services provided by the state's mobile field hospital. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy. Mobile field hospital means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the provision of medical services at a mass gathering; for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure.

Please contact the Insurance Department Life and Health Division at ctinsdept@ct.gov with any questions about the Public Acts in this notice.



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Insurance Commissioner