

**Legislative Regulation
Review Committee**

2010-013

Insurance Department

**INDIVIDUAL SPECIFIED DISEASE
INSURANCE POLICIES**

**STATE OF CONNECTICUT
REGULATION
OF**

NAME OF AGENCY
INSURANCE DEPARTMENT

Individual Accident and Sickness Minimum Standards

Section 1. Section 38a-505-13 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-505-13. Specified Disease Policies

(a) A "specified disease policy" means an individual health insurance policy delivered or issued for delivery in this state [on or after May 31, 1997] which pays benefits for the diagnosis [and] or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38a-505-13 (c) of the Regulations of Connecticut State Agencies. As used in this section, "condition" includes specifically named diseases, conditions or syndromes unless the context otherwise requires. Any specified disease policy shall meet the general requirements in subsection (b) of this section and the minimum benefit standards pursuant to subsection (c) of this section.

(b) General Requirements:

The following requirements shall apply to specified disease policies in addition to all other requirements applicable to individual accident and sickness policies.

(1) Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease policies.

(2) Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered condition, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis shall be accepted in lieu thereof.

(3) Notwithstanding any other provision of this section, specified disease policies described in Section 38a-505-13 (c)(1) and Section 38a-505-13 (c)(2) of the Regulations of Connecticut State Agencies shall provide benefits to any covered person not only for a specified condition but also for any other condition or disease, directly caused or aggravated by the specified condition or its treatment.

(4) Specified disease policies shall be at least guaranteed renewable.

(5) No policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. Premiums paid shall be refunded if the insured is diagnosed with a covered condition during the waiting or probationary period.

(6) Payment of benefits may be conditioned upon a covered person receiving medically necessary care or treatment.

(7) Any application for a specified disease policy shall contain a prominent statement above the signature of the applicant that a person who is already covered by Medicaid should not purchase this coverage. Such statement shall be in bold face type or contrasting color.

(8) The benefits of a specified disease policy shall be paid regardless of other coverage.

(9) Benefit payments under specified disease policies described in Section 38a-505-13 (c)(1) and Section 38a-505-13 (c)(2) of the Regulations of Connecticut State Agencies shall begin with the first day of care or confinement after the effective date of the policy if such care or confinement is for a covered condition even though the diagnosis of a covered condition is made at some later date (but not retroactive more than ninety (90) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of such covered condition.

(10) Specified disease policies shall provide a thirty (30) day free look. Notice of the thirty (30) day free look shall appear on the face page of the policy in bold face equal to at least fourteen (14) point type.

(11) Specified disease policies shall contain a prominent statement on the first page of the policy in bold face type at least equal to fourteen (14) point type as follows: "CAUTION! This [is a limited] policy provides limited coverage. It is not a major medical policy. Read it carefully. It only pays benefits for [specified condition] treatment (or diagnosis) of (specified disease).

(12) The premiums for a policy shall be reasonable in relation to benefits and shall not be excessive or inadequate. The insurer shall establish premiums for specified disease policies in accordance with generally accepted actuarial principles and practices so as to return to

**STATE OF CONNECTICUT
REGULATION
OF**

NAME OF AGENCY
INSURANCE DEPARTMENT

policyholders in the form of aggregate benefits provided under the policy during the period for which rates are computed at least 65 percent of the aggregate premiums earned. The insurer may also charge an annual policy fee of up to thirty dollars (\$30.00), which fee shall be excluded from premium for the purposes of the 65 percent calculation. Each insurer shall annually report by June 30 earned premiums and incurred claims for the prior calendar year for each approved specified disease policy form in a format acceptable to the insurance commissioner.

(13) " Preexisting condition " shall not be defined to be more restrictive than the following: Preexisting condition means [the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a twelve (12) month period preceding the effective date of the coverage of the insured person, or] a condition for which medical advice or treatment was recommended by a physician or received from a physician within a twelve (12) month period preceding the effective date of the coverage of the insured person. No policy shall exclude for a loss due to a preexisting condition for a period greater than twelve (12) months following policy issue.

(c) Each specified disease policy shall meet the minimum benefit standards provided in [either] subdivision [(1) or (2)] (1), (2) OR (3) of this subsection. In addition, a specified disease policy may combine coverages of the types described in subdivisions (1), (2), and (3) of this subsection. A policy that combines coverages and meets the minimum benefit standard requirements set forth in subdivision (1), (2), or (3) of this subsection may be approved for sale in the state if it includes some, but not all, of the benefits otherwise permitted by another type of specified disease policy, except that policies combining coverage of the types described in subdivisions (1) and (2) of this subsection shall meet the minimum requirements for each type of coverage.

(1) Coverage for medical expenses incurred by each person insured under the policy for one or more specifically named diseases, conditions or syndromes, with a deductible amount not in excess of \$1,000, co-insurance by the insured not to exceed 25%, and an overall aggregate lifetime benefit limit, per person, of not less than \$250,000. Any inside limits shall be reasonable. Policy benefits shall include:

- (A) Hospital room and board and hospital furnished medical services or supplies;
- (B) Treatment by, or under the direction of, a physician or surgeon;
- (C) Private duty services of a registered nurse (R.N.) or a Licensed Practical Nurse (L.P.N.);
- (D) X-ray, radium, cobalt, nuclear medicine, chemotherapy, and other therapeutic procedures used in diagnosis and treatment;
- (E) Licensed ambulance for local service to or from a local hospital;
- (F) Blood transfusions, and plasma, and the administration thereof;
- (G) Drugs and medicines prescribed by a physician;
- (H) The rental of any respirator or other mechanical apparatus;
- (I) Braces, crutches, wheelchairs and other adaptive devices deemed necessary by the attending physician because of the incapacitating nature of the covered condition;
- (J) Transportation beyond the local area for medically necessary treatment;
- (K) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his assistant) performing the surgical service, in an amount not less than (i) 80% of the reasonable charges, or (ii) fifteen percent (15%) of the surgical service benefit;
- (L) Home health care as described in Section 38a-493(d) of the general statutes;
- (M) Physical, speech, hearing and occupational therapy for symptoms related to the covered condition;
- (N) Special equipment and supplies, including, but not limited to hospital bed, bedpans, pulleys, wheelchairs, aspirator, disposable diapers, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;
- (O) Reconstructive surgery when medically necessary;
- (P) Prosthetic devices including wigs and artificial breasts;
- (Q) Nursing home care;
- (R) Hospice care; and

**STATE OF CONNECTICUT
REGULATION
OF**

NAME OF AGENCY
INSURANCE DEPARTMENT

(S) any other expenses necessarily incurred in the care and treatment of the covered condition.
(2) Per diem indemnification for each person insured under the policy for a specifically named disease, condition or syndrome with no deductible amount, and an overall aggregate benefit limit of not less than \$250,000 while medically confined, subject to the following minimum benefit standards:

(A) A fixed-sum payment of at least \$150.00 for each day of hospital confinement;
(B) A fixed-sum payment equal to at least \$100.00 for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy; and

(C) A fixed-sum payment equal to one-half of the hospital in-patient benefit for each day of nursing home care, hospice care, [or] and home health care for at least 100 days.

(3) A fixed-sum one-time payment made not more than thirty (30) days after submission to the insurer of proof of diagnosis of the specified disease, of not less than one thousand dollars (\$1,000). In addition, payment amounts may be limited to not less than two hundred fifty dollars (\$250) for one or more specified diseases where coverage is provided under such policy for two or more specified diseases, provided that the aggregate amount payable under the policy for all specified diseases is at least one thousand dollars(\$1,000). Also, coverage for a fixed-sum payment for a spouse or dependent may be offered to the insured, provided the benefit amount offered is at least twenty-five per cent (25%) of the benefit amount for the insured. Where coverage is advertised or otherwise represented to offer generic coverage of a specified disease, the same dollar amounts shall be payable, regardless of the particular subtype of the disease, unless such subtype is clearly identifiable and the policy clearly differentiates that subtype and its benefits.

(d) No specified disease policy shall be delivered or issued for delivery in this State unless an outline of coverage in the form prescribed below is completed and is delivered with the policy or at the time of application for the policy. The items included in the outline of coverage shall appear in the sequence prescribed below:

CAUTION!

(COMPANY NAME)

(SPECIFIED CONDITION) COVERAGE

OUTLINE OF COVERAGE

(1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions shall control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) (Specified condition) Coverage — This policy is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (specified condition) treatment (or diagnosis). This policy does NOT provide general health insurance.

(3) This policy is NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from (the company).

(4) (A brief specific description of the benefits, including dollar amounts, contained in this policy.)

(5) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (4) above.)

(6) (A description of policy provisions respecting renewability, including age restrictions and any reservation of right to change premiums.)

[(e) This section shall be effective May 31, 1997.]

Statement of Purpose:

To provide clarification and expansion of the types of specified disease policies which may be sold in the individual health insurance market in the state.

**STATE OF CONNECTICUT
REGULATION
OF**

**NAME OF AGENCY
INSURANCE DEPARTMENT**

A. The problems, issues or circumstances that the regulation proposes to address.

This amendment to the existing regulation will permit a new category of individual specified disease policy to be sold in Connecticut.

B. A summary of the main provisions of the regulation

The amended regulation will permit health insurers to offer a fixed sum one time payment individual specified disease policy in addition to the two existing categories of individual specified disease policies currently permitted in the state (which are coverage for medical expenses incurred and per diem indemnification). The regulation also describes the rules for when a health insurer combines two or more of the three types of coverages into a single policy.

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

There is no impact on existing laws. This amendment would alter the existing Regulation, Section 38a-505-13, as indicated above.

CERTIFICATION

R-39 REV. 1/77

Be it known that the foregoing:

Page _____ of _____ pages

Regulations Emergency Regulations

Are:

Adopted Amended as hereinabove stated Repealed

By the aforesaid agency pursuant to:

Section 38a-8 and 38a-505 of the General Statutes.

Section _____ of the General Statutes, as amended by Public Act No. _____ of the _____ Public Acts.

Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on, January 13, 2009 of the notice of the proposal to:

Adopt Amend Repeal such regulations

(If applicable): And the holding of an advertised public hearing on _____ day of _____ 20 _____

WHEREFORE, the foregoing regulations are hereby:

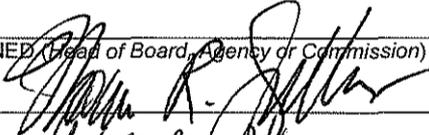
Adopted Amended as hereinabove stated Repealed

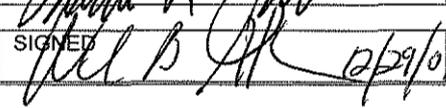
Effective:

When filed with the Secretary of the State.

(OR)

The _____ day of _____.

In Witness Whereof:	DATE <u>12/16/09</u>	SIGNED (Head of Board, Agency or Commission) 	OFFICIAL TITLE, DULY AUTHORIZED INSURANCE COMMISSIONER
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Approved by the Attorney General as to legal sufficiency In accordance with Sec. 4-169, as amended, C. G. S. :	SIGNED 	OFFICIAL TITLE, DULY AUTHORIZED ASSOC. ATTY GENERAL
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- Approved
- Disapproved
- Disapproved in part, (Indicate Section Numbers disapproved only)
- Rejected without prejudice.

By the Legislative Regulation Review Committee in accordance With Sec. 4-170, as amended, of the General Statutes.	DATE	SIGNED (Clerk of the Legislative Regulation Review Committee)
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Two certified copies received and filed, and one such copy forwarded to the Commission on Official Legal Publications
In accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State.)	BY
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INSTRUCTION

1. One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.
2. Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.
3. Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.
4. Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capitol letters and deleted language in brackets. Section 4-170 of the General Statutes.