Addendum: for use with Connecticut Health online ExamFX course and study guide version 22003en, per exam content outline updates effective 09/01/2021.

***Please note that Connecticut is changing testing providers. Effective 9/1/2021, state insurance exams will be administered by Pearson Vue**. For additional information about exam requirements and complete exam content outlines, please review the Insurance Licensing Candidate Handbook at* www.pearsonvue.com/ct/insurance.

Note that the exam format is changing, as well. The new exam will consist of 2 parts: General Knowledge and State Law. However, you will receive one overall score. The new exam breakdown is as follows:

Connecticut Accident & Health Insurance Examination
90 Total Questions (75 scored, 15 pretest)
Time Limit: 2 hours; Passing Score: 70%

Chapter	Percentage of Exam
GENERAL KNOWLEDGE:	
Field Underwriting Procedures	12%
Types of Health Policies	19%
Policy Provisions, Clauses, and Riders	27%
Social Insurance	4%
Other Insurance Concepts	5%
STATE LAW:	
State Statutes, Rules, and Regulations Common to All Lines	24%
State Statutes, Rules, and Regulations Pertinent to Accident and Health Insurance Only	9%

*The following are **content additions** to supplement your existing text:*

Health Insurance Basics

Modes of Premium Payment

In regard to insurance premiums, mode refers to the **frequency** the policyowner pays the premium. An insurance policy's rates are based on the assumption that the premium will be paid annually at the beginning of the policy year and that the company will have the premium to invest for a full year before paying any claims. If the policyowner chooses to pay the premium more frequently than annually, there will be an additional charge because the company will have additional expenses in billing the premium. However, the premium may be paid annually, semi-annually, quarterly, or monthly.

Higher Frequency = Higher Premium

Monthly > Quarterly > Semi-Annual > Annual

Copyright © 2021 ExamFX

Subrogation

Subrogation is the legal process by which an insurance company seeks recovery of the amount paid to the insured from a third party who may have caused the loss. Through subrogation, the **insured cannot collect twice**.

D. Limited Policies

Cancer Policy

Cancer policies cover only one illness: cancer, and pay a lump-sum cash benefit when the insured is first diagnosed with cancer. It is a supplemental policy intended to fill in the gap between the insured's traditional health coverage and the additional costs associated with being diagnosed with the illness. There are no restrictions on how the insured spends the funds, so the benefit can be used to pay for medical bills, experimental treatment, mortgage, personal living expenses, loss of income, etc.

Critical Illness

A **critical illness** policy covers multiple illnesses, such as heart attack, stroke, renal failure, and pays a lump-sum benefit to the insured upon the diagnosis (and survival) of any of the illnesses covered by the policy. The policy usually specified a minimum number of days the insured must survive after the illness was first diagnosed.

Short-Term Medical

Short-term medical insurance plans are designed to provide temporary coverage for people in transition (those between jobs or early retirees), and are available for terms from one month up to 11 months, depending on the state. Unlike regular individual major medical plans, short-term health insurance policies are not regulated by the Affordable Care Act and their enrollment is not limited to the open enrollment period; they also do not meet the requirements of the federally mandated health insurance coverage.

Like traditional health plans, short-term plans may have medical provider networks, and impose premiums, deductibles, coinsurance and benefit maximums. They also cover physician services, surgery, outpatient and inpatient care.

Individual Health Insurance Policy General Provisions

C. Other General Provisions

Probationary Period

The **probationary period** provision states that a period of time must lapse before coverage for specified conditions goes into effect. This provision is most commonly found in disability income policies. The probationary period also applies to new employees who must wait a certain period of time before they can enroll in the group plan. The purpose of this provision is to avoid unnecessary administrative expenses in cases of employee turnover.

Copyright © 2021 ExamFX

Exclusions and Limitations

Exclusions specify for what the insurer will not pay. These are causes of loss that are specifically excluded from coverage. **Reductions** are a decrease in benefits because of certain specified conditions. The most common exclusions in health insurance policies are injury or loss that results from any of the following:

- War;
- Military duty;
- Self-inflicted injury;
- Dental expense;
- Cosmetic medical expenses;
- Eye refractions; or
- Care in government facilities.

In addition, most policies will temporarily suspend coverage while an insured resides in a foreign country or while serving in the military.

Mental and Emotional Disorders — Usually the lifetime benefit for major medical coverage limits the amount payable for mental or emotional disorders. The benefit is usually expressed as a separate lifetime benefit and there is frequently a limit on the number of outpatient visits per year. The benefit may also pay a maximum limit per visit. These limitations usually do not apply to inpatient treatment.

Substance abuse — As with mental and emotional disorders, outpatient treatment of substance abuse is usually limited to a maximum limit.

Coinsurance

Most major medical policies include a **coinsurance** provision that provides for the sharing of expenses between the insured and the insurance company. After the insured satisfies the policy deductible, the insurance company will usually pay the majority of the expenses, typically **80%**, with the insured paying the remaining **20%**. Other coinsurance arrangements exist such as 90/10; 75/25; or 50/50. The larger the percentage that is paid by the insured, the lower the required premium will be. The purpose of the coinsurance provision is for the insurance company to control costs and discourage overutilization of the policy.

Copayments

A **copayment** provision is similar to the coinsurance feature in that the insured shares part of the cost for services with the insurer. Unlike coinsurance, a copayment has a **set dollar amount** that the insured will pay each time certain medical services are used.

Deductibles

A **deductible** is a specified dollar amount that the insured must pay first before the insurance company will pay the policy benefits. The purpose of a deductible is to have the insured absorb the smaller claims, while the coverage provided under the policy will absorb the larger claims. Consequently, the larger the deductible, the lower the premium that is required to be paid.

Copyright © 2021 ExamFX

Most major medical policies feature an **annual deductible** (also called a calendar year deductible) that, as the name implies, is paid once in any year, regardless of the amount of claims in that year. The policy may contain an **individual deductible**, in which each insured is personally responsible for a specified deductible amount each year, or a **family deductible** (usually 2 to 3 times the individual deductible) whereby the annual deductible is satisfied if two or more family members pay a deductible in a given year, regardless of the amount of claims incurred by additional family members. Some policies contain what is known as a **per occurrence deductible** or **flat deductible** which the insured is required to pay for each claim, possibly resulting in more than one deductible being paid in a given year.

The policy may also contain a provision which applies when more than one family member is injured in a single accident, also called the **common accident provision**. In this case, only one deductible applies for all family members involved in the same accident.

Some supplemental major medical plans also include an **integrated deductible** in which case the amount of the deductible may be satisfied by the amount paid under basic medical expense coverage. For example, if the supplemental coverage included a $1,000 integrated deductible, and the insured incurs $1,000 in basic medical expenses, the deductible will be satisfied. If the basic policy only covered $800 of the basic expenses, the insured would have to satisfy the remaining $200 difference.

Some policies also include a **carry-over provision** that states that if the insured did not incur enough expenses during the year to meet the deductible, any expenses incurred during the last 3 months may be carried over to the next policy year to satisfy the new annual deductible.

Disability income and long-term care policies usually have a **time deductible** in the form of elimination period.

Eligible Expenses

Eligible expenses are those medical expenses covered by a health insurance plan. The eligible expenses are specified in the policy.

Pre-Authorization and Prior Approval Requirements

Some health insurance policies will require the pre-authorization or prior approval of certain medical procedures, tests, or hospital stays. The insured must obtain the insurer's approval before the procedure, test, or hospital stay to be sure the policy will cover the expenses.

Usual, Reasonable and Customary (URC) Charges

Some medical expense insurance plans contain a **benefit schedule**, which very specifically states exactly what is covered in the plan and for how much. Other plans may incorporate the term **usual/reasonable/customary**. Usual/reasonable/customary means that the insurance company will pay an amount for a given procedure based upon the average charge for that procedure in that specific geographic area.

Copyright © 2021 ExamFX

Impairment Rider

The **impairment** (exclusion) rider may be attached to a contract for the purpose of eliminating coverage for a specifically defined pre-existing condition, such as back injuries. Impairment riders may be temporary or may become a permanent part of the policy. Attaching this rider excludes coverage for a condition that would otherwise be covered. Often a person's only means of purchasing insurance at a reasonable cost when they have an existing impairment is through a policy which excludes coverage for the specific impairment.

For example, a physician may have suffered from a back injury prior to applying for a disability policy. The company may agree to issue a disability policy, but with an exclusion rider, excluding coverage for any claim related to his back. The policy would cover any other disability he may incur in the future, as long as it is not related to his back. This may be the only way the insured is able to obtain coverage. The underwriter makes a decision when writing the contract whether to make the exclusion permanent, or, for a short time only (such as if the insured is able to go a specified period of time with no further treatment). The terms of the rider will be clearly stated in the policy.

Most riders in both life and health insurance add some form of additional coverage and often, there is extra cost added to the premium for the rider. The impairment (exclusion) rider is an exception in that it takes something **away from** standard coverage. There is no extra charge for this, nor is the premium reduced to reflect a reduction in coverage.

Guaranteed Insurability Rider

This policy rider is also referred to as the **Future Increase Option** or the **Guaranteed Purchase Option**. This option, which is also available on life insurance policies, will allow the insured to purchase additional amounts of disability income coverage without evidence of insurability. The insured is usually provided a number of option dates, such as every two years, on which the additional purchase option may be exercised. Most companies do not allow the insured to exercise the additional purchase option beyond a certain age, usually age 50. The premium for the additional amount of insurance will be based on the insured's attained age at the time the option is exercised. In order to prevent over-insurance, the insured must meet an earnings test prior to each purchase. In addition, the insurer will usually limit the amount that may be purchased at each of the option dates to some specified amount, such as $500-$5,000.

Primary and Contingent Beneficiaries

Any death benefits available in a policy will be paid to a beneficiary. A **primary beneficiary** is the first person so designated. However, if the primary beneficiary should die before the benefits become payable, the benefits would go to a **contingent** or **secondary beneficiary**. If no beneficiary is designated, the benefits will be placed in the deceased's estate.

Multiple primary and contingent beneficiaries may be designated in a policy. If multiple primary beneficiaries are named, each individual will receive a proportionate percentage of the death benefit. If one of multiple primary beneficiaries dies, equivalent percentages are re-established.

Copyright © 2021 ExamFX

For example, if there were two primary beneficiaries named in a policy, each would receive 50% of the death benefit. If one of the two beneficiaries died, the remaining beneficiary would receive 100%.

If an individual health insurance policy provides a death benefit, it must also include a **change of beneficiary** provision. This provision gives the policyholder, unless he/she has made an irrevocable designation of a beneficiary, the right to change any primary and/or contingent beneficiary or make any other change without the consent of the beneficiary or beneficiaries.

Owner's Rights

If an individual health insurance policy provides a death benefit, the policyowner will be able to designate a beneficiary and to change the beneficiary unless the beneficiary designation is irrevocable. The power to **change the beneficiary** is provided in the change of beneficiary provision. The policyowner also has the right to make any other change without the consent of the beneficiary(ies).

Medical Plans

B. Types of Plans

Flexible Spending Accounts (FSAs)

A **Flexible Spending Account** (FSA) is a form of cafeteria plan benefit funded by salary reduction and employer contributions. The employees are allowed to deposit a certain amount of their paycheck into an account before paying income taxes. Then, during the year, the employee can be directly reimbursed from this account for eligible health care and dependent care expenses. FSA benefits are subject to annual maximum and "use-or-lose" rule. This plan does not provide a cumulative benefit beyond the plan year.

There are 2 types of Flexible Spending Accounts: a Health Care Account for out-of-pocket health care expenses, and a Dependent Care Account (subject to annual contribution limits) to help pay for dependent's care expenses which makes it possible for an employee and his or her spouse to continue to work.

An FSA is exempt from federal income taxes, Social Security (FICA) taxes and, in most cases, state income taxes, saving 1/3 or more in taxes. If the plan favors highly compensated employees, the benefits for the highly compensated employees are not exempt from federal income taxes.

Child and dependent care expenses must be for the care of one or more qualifying persons:

- A dependent who was under age 13 when the care was provided and who can be claimed as an exemption on the employee's Federal Income Tax return;
- A spouse who was physically or mentally not able to care for himself or herself; or
- A dependent who was physically or mentally not able to care for himself or herself and who can be claimed as an exemption (as long as the person is earning gross income less than an IRS-specified amount).

Copyright © 2021 ExamFX

Persons who cannot dress, clean, or feed themselves because of physical or mental problems are considered not able to care for themselves. Also, persons who must have constant attention to prevent them from injuring themselves or others are considered not able to care for themselves.

The insured may change benefits during open enrollment. After that period, generally, no other changes can be made during the plan year. However, the insured might be able to make a change under one of the following circumstances, referred to as *qualified life event* changes:

- Marital status;
- Number of dependents;
- One of dependents becomes eligible for or no longer satisfies the coverage requirements under the Medical Reimbursement plan for unmarried dependents due to attained age, student status, or any similar circumstances;
- The insured, the insured's spouse's or qualified dependent's employment status that affects eligibility under the plan (at least a 31-day break in employment status to qualify as a change in status);
- Change in dependent care provider; or
- Family medical leave.

The IRS limits the annual contribution for Dependent Care Accounts to a specified amount that gets adjusted annually for cost of living. This is a family limit, meaning that even if both parents have access to flexible care accounts, their combined contributions cannot exceed the amount.

E. Federal Legislature

2. PPACA (Patient Protection and Affordable Care Act)

Taxes and Subsidies

Enrollment in the Health Insurance Market place began in October 2013, and tax credits for those who qualify became available in 2014.

After submitting an application for health insurance for a qualified health plan, **individuals** will be able to take an advance tax credit to reduce the cost of their health care coverage if purchased through an exchange. For the purposes of the premium tax credit, household income is defined as the Modified Adjusted Gross Income (MAGI) of the taxpayer, spouse, and dependents. The MAGI calculation includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security.

Legal residents and citizens who have incomes **between 100% and 400%** of the Federal Poverty Level (FPL) are eligible for the tax credits. States have the option of extending Medicaid coverage to people under 138% of the FPL. Persons who receive public coverage like Medicare or Medicaid are not eligible for the tax credits.

Persons who are eligible for a premium tax credit and have household **incomes between 100% and 250%** of FPL are eligible for cost-sharing subsidies (reductions). Eligible individuals will be required to purchase a silver level plan in order to receive the cost-sharing subsidy.

Copyright © 2021 ExamFX

The tax credit is sent directly to the insurance company, and reduces the insured's monthly health care premiums. Tax credits are based upon the individual's or family's expected annual income.

Small employers that offer health plans may be eligible for federal tax credits, depending on the average wages and size of the employer. These tax credits, available to low-wage employers (under $50,000 average per employee) with 25 or fewer workers, may cover up to 50% of premiums paid for small business employers and 35% of premiums paid for small tax-exempt employers.

To be eligible for the credit, a small employer must pay premiums on behalf of employees enrolled in a qualified health plan offered through a Small Business Health Options Program (SHOP).

The credit is available to eligible employers for 2 consecutive taxable years.

Employer Notification Responsibilities

All employers that offer health coverage to their employees are required to provide information about the Patient Protection and Affordable Care Act and the new Health Insurance Marketplace exchanges. The purpose of the notification is to help employees evaluate health insurance options for them and their dependents.

Insurance Regulation

Broker

A **broker** is an insurance producer that is not appointed by an insurance company and is deemed to be representing the client in matters of insurance.

Transacting Insurance

Transacting insurance is the process of conducting insurance business. An insurance transaction includes the following:

- Solicitation of applications for insurance;
- Collecting premiums, fees, and assessments for insurance contracts;
- Issuing and delivering insurance policies; and
- Directly and indirectly acting as an insurance agent.

Filing and Approval of Policy Forms

The written policy forms, including endorsements, that are to be used by an insurance company must be filed and approved by the Insurance Department prior to their use in the state. The filing may be done on paper or in electronic form, but must be in a format prescribed by the Department.

After a form is accepted for review, the Department of Insurance will approve or disapprove the form within **90 days**. If the Department determines that additional information from the insurer is necessary, they will make a request to the insurer. The insurer, then, has 10 days to provide the requested information.

Copyright © 2021 ExamFX

Disclosure

In most cases, if an insurance producer receives compensation directly from a customer at the initial placement, that compensation cannot be accepted unless the producer has **disclosed** to the customer the amount of compensation the producer will receive. If the amount of compensation is not known at the time of disclosure, the producer must explain the method for calculation such compensation and provide a reasonable estimate.

Premium Accountability

Each authorized insurance company is required to report to the Commissioner any failure on the part of the producer to remit premiums for policies issued through the producer **within 30 days**, or any instance where a check issued by a producer is returned for insufficient funds.

If the producer is found guilty of a failure to remit the premiums on issued policies to the insurer, his or her license may be suspended or revoked. The Commissioner will send a notice to the producer to remit the premiums. The following time limits will then apply:

- **15 days** for the producer to pay the funds; otherwise, the producer's license will be automatically suspended;
- **60 days** for the producer to request a hearing – if no hearing is requested and no premiums are remitted, the license will be revoked;
- A hearing must take place **30 days** from the receipt of the written request.

Brokered Transactions Guarantee Fund

The Insurance Department must establish and maintain a **Brokered Transactions Guaranty Fund.** Any resident aggrieved by a business action of a licensed surplus lines broker or an unlicensed person acting as a producer who embezzled money or property, or illegally obtained money or property by reason of fraud, misrepresentation or deceit, may recover, with the Department's approval, compensation in an amount not exceeding a total of $10,000. This excludes failure in the performance of contractual obligations due to the impairment of an insurer.

Unfair and Prohibited Practices

Illegal Inducement

It is unlawful to pay, offer or accept any of the following as an **inducement** to buy insurance:

- Any special favor or advantage in dividends or benefits;
- Any stocks, bonds, securities, or accrued dividends or profits; or
- Anything of value not specified in the insurance contract.

Coercion of Borrower

It is illegal for an insurer or an insurance producer to engage in any activity that will either create for itself a monopoly or will in any way force a person to believe he or she

Copyright © 2021 ExamFX

must buy insurance from a particular producer or insurer to comply with a creditor's or lender's insurance requirement.

State Statutes Rules, and Regulations Pertinent to Accident and Health Insurance Only

Policy Clauses and Provisions

Minimum Standards

As a means of protecting health insurance consumers, individual and group medical expense policies sold in the state must conform to a minimum level of standards set by the Connecticut Insurance Department.

Definition

Health insurance policy means insurance providing benefits due to illness or injury, resulting loss of life, loss of earnings, or expenses incurred, and includes the following types of coverage:

- Basic hospital expense coverage;
- Basic medical-surgical expense coverage;
- Hospital confinement indemnity coverage;
- Major medical expense coverage;
- Disability income protection coverage;
- Accident only coverage;
- Long-term care coverage;
- Specified accident coverage;
- Medicare Supplement coverage;
- Limited benefit health coverage;
- Hospital or medical service plan contract;
- Hospital and medical coverage provided to subscribers of a health care center; and
- Specified disease coverage.

The insurance regulations require that individual accident and sickness insurance policies issued and delivered in this state may only contain definitions that comply with those set by the Code.

Prohibited Provisions

All individual health insurance policies sold in this state must adhere to the following provision:

- Probation waiting periods may not exclude coverage for accident-related claims at all, and are limited to 6 months for cases where the cause of disability or medical treatment is related to certain specified diseases (hernia, varicose veins, tonsils, appendix, etc.).
- Disability income policies may include a return of premium provision as long as the policy is noncancellable, is not issued beyond age 50, the insurer provides a clear and complete explanation of how the benefit is calculated, a surrender value is

available within 3 years, and the policy surrender value may be obtained either upon the surrender of the policy, the policyowner's death or expiration of the policy.
- No other type of health insurance (other than disability income policies) may offer a return of premium provision.

Required and Options Coverages

Mental Health and Nervous Disorder Coverages

Each individual health insurance policy must provide benefits for the diagnosis and treatment of mental or nervous conditions. Mental or nervous conditions means mental disorders, and does not include

- Intellectual disability;
- Learning disorders;
- Motor skills disorders;
- Communication disorders;
- Caffeine-related disorders;
- Relational problems; and
- Additional conditions that may be a focus of clinical attention.

Policy terms and benefits for mental and nervous conditions must be equal to those for diagnosis and treatment of other medical, surgical or physical health conditions.

Substance Abuse Treatment

Every group health insurance policy that provides basic or major hospital or medical-surgical expense coverage must also provide coverage for treatment of substance abuse or medical complications of alcoholism, which would include diseases like cirrhosis of the liver, gastrointestinal bleeding, pneumonia or delirium tremens. Confinement for medical complications of alcoholism is provided on the same basis as any other disease specified in the contract. The benefits may be excluded if they are covered by a separate policy issued by the same group.

Maternity Benefits for Dependent Children

Health insurance policies that provide maternity benefits and provide health coverage for the insured's family must also provide maternity benefits for covered dependent children. Coverage for a newborn must cover injury and sickness, as well as treatment of diagnosed congenital defects and birth abnormalities.

Health insurance policies requiring a specific premium or subscription fee may require notification of birth within 61 days for coverage to continue on a newborn.

Pre-existing Conditions

The term pre-existing conditions cannot be more restrictive than the following: existing of symptoms which would cause a person to seek diagnosis, care or treatment, or for which medical advice or treatment was recommended or provided by a physician within **5 years** preceding the effective date of coverage. Pre-existing condition provision in health policies limits or excludes benefits for that condition.

The following, however, are **exceptions** to the pre-existing condition regulation:

- Routine follow-up care to determine whether a breast cancer has reoccurred in a person previously determined to be breast cancer free is not considered medical advice or care.
- Genetic information cannot be treated as a condition in the absence of a diagnosis.
- Pregnancy is not considered a pre-existing condition.

Chiropractic

Every individual medical expense policy must provide coverage for chiropractic services to the same extent coverage is rendered by a physician, as long as its purpose is to treat a condition that is covered under the policy and is within the services the chiropractor is licensed to perform.

Mammogram

Individual health insurance policies must provide for women covered under the policy:

- 1 baseline mammogram for any woman age 35 to 39 inclusive;
- 1 mammogram every year for any woman age 40 or older.

Carrier Disclosure

Renewal Agreements, Nonrenewal, and Cancellation

All health insurance policies must include a provision explaining the terms and conditions under which the policy may be renewed or cancelled.

Guaranteed renewable and **noncancelable** policies must clearly state the term that the policy is guaranteed renewable (e.g. age 65). The insurer cannot cancel or refuse to renew a policy while it is guaranteed renewable or noncancelable. Premium rates for guaranteed renewable policies may be increased only for the entire class of policies. Noncancelable policies not only guarantee that the policy will be renewed, but guarantee the premium rate.

Group health insurance policies must permit covered employees whose employment is terminated or reduced to continue coverage if the group policy remains in force. (This does not apply to termination for gross misconduct.)

Suitability

It is the agent's responsibility to exercise due diligence to determine if a proposed policy is suitable for the applicant. The proposed insurance needs to meet the needs of the applicant and be affordable.

Policy Replacement

To protect the consumer against suffering, damage or loss because of the unnecessary changing of health insurance policies (new waiting periods, higher premium rates, etc.), the Commissioner has established regulations governing the replacement of policies.

Copyright © 2021 ExamFX

In group medical policies, when a replacement medical policy is issued, the following rules apply:

- The prior insurer remains liable only for claims arising before the replacement, even though the expenses occur after the new policy is issued, except in cases where benefits are extended for any reason;
- The succeeding insurer must allow all those who participated in the prior insurer's plan to be eligible for participation in the new plan;
- Plan participants who have a pre-existing condition when the replacement occurs must be covered for that condition. Benefits must be at least equal to the lesser of the succeeding plan's benefits or the previous plans benefits; and
- Deductibles and coinsurance amounts paid before the replacement must be recognized by the succeeding plan when determining benefit levels.

Application Responsibilities

Making a false or fraudulent statements or misrepresentations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer, or individual is an illegal act.

Insurance providers or agents must give a **notice of information practices** with every application for insurance either at the time of policy delivery or at the time the applicant's personal information is collected. The notice must be in writing, and must explain the types of personal information that may be collected, the required disclosures, and a description of the applicant's rights.

Medicare Supplement Insurance

Definitions

Connecticut law defines a Medicare Supplement policy as

- A group or individual policy of accident and sickness insurance;
- A subscriber contract of hospital and medical service corporations or health care centers, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act; or
- An issued policy under a demonstration project specified in the federal code, which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Except as otherwise specifically excluded, this applies to all Medicare supplement policies and certificates delivered or issued for delivery in Connecticut.

Nonduplication of Benefits

A Medicare supplement policy may not duplicate any benefit that is provided under Medicare. Issuers must report to the Insurance Commissioner annually (on or before March 1) information regarding any state resident who has in force more than one Medicare supplement policy of certificate. The report must include the policy and certificate number, and the date of issuance.

Copyright © 2021 ExamFX

Long-Term Care/Home Health Care Policies

Long-term care insurance is any policy designed to provide the insured with at least **1 year** of coverage after a reasonable elimination period for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, or personal care services in a setting other than an acute care unit of a hospital.

Long-term care coverage may be issued by an insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center that is authorized to issue such coverage by the Commissioner.

Long-term care insurance is a recent innovation, prompted by the enormous costs that can be associated with the health care needs of the aged. With the increase in life expectancy and improved medical care, people are living longer.

There are several standard provisions that are required in all long-term care policies issued and delivered in this state - individual, group and direct response. Those provisions include, but are not limited to the following:

- LTC policies cannot deny a claim for a pre-existing condition that occurred more than 6 months from the effective date of the policy;
- Limitations and Exclusions: LTC policies cannot impose limitations or exclusions that are more restrictive than in any other health insurance policies;
- LTC policies cannot use waivers to exclude, limit or reduce coverage for specifically named pre-existing diseases of physical conditions;
- Waiver of premium: policies must make reasonable provision for waiver of premium;
- Right to return: a notice must be printed on the first page of the policy explaining the policyowner's right to return the policy within 30 days for a full refund of the premium (direct response policies must be returned to the insurer; policies solicited through an agent may be returned to the agent or the insurer);
- Return of premium: policies must include a provision stating that upon notification to the company of an insured's death, the company will refund the premium on a pro rata basis;
- Elimination period cannot be greater than 100 days of confinement;
- Extension of benefits and payment of benefits.

All group LTC policies must include a continuation of coverage provision that allows the certificate holder to continue coverage or convert to an individual policy if the group plan is cancelled or nonrenewed.

Individual policies must include a renewability provision, either guaranteed renewable or noncancellable. That provision must appear on the first page of the policy and clearly state the duration of the term of coverage for which the policy is issued or may be renewed.

Copyright © 2021 ExamFX

Nursing Home vs. Home vs. Community

Long-term care insurance may provide benefits to insureds confined in a nursing home, at home, or to residents of a life care or continuing care retirement community or other residential community for the elderly.

The Commissioner may, upon written request by the issuer of the coverage, issue an order to modify or suspend a specific provision or regulation adopted with respect to a specific long-term policy upon a written finding that

- The modification or suspension would be in the best interest of the insureds;
- The purposes to be achieved could not be effectively or efficiently achieved without such modification or suspension; and
- The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care.

Levels of Care

Long-term care policies that provide benefits for home health care services only (and not for nursing home care) do not have to meet policy requirements relating to long-term care in a nursing facility. However, they must meet all other long-term care policy requirements.

There are three levels of care that may be provided under a long-term care policy:

- Skilled nursing care;
- Intermediate care; and
- Custodial or residential care.

Of these levels of care, custodial care is what most elderly persons will require at some time in their lives and is also the type of care that is not covered by Medicare.

Zero-Day Hospital

Long-term care policies cannot condition benefits on whether or not the insured has been hospitalized for a certain period of time before benefits become available.

Spousal Discount

Most companies offer a spousal discount of premium if both husband and wife purchase long-term care coverage from them.

Reinstatement of Used Benefits

Long-term care insurance policies are written with a benefit limit per day and a lifetime benefit amount. When a spouse is included for coverage on a rider attached to the policy, upon admission to a long-term care facility, the limit is restored for that insured.

Copyright © 2021 ExamFX

Related Terms

Community care refers to a program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, and other disabled adults who can benefit from care in a group setting.

Alternate care refers to care provided outside the person's home, but in a setting other than a long-term care facility.

Case management is the process of managing the care of an insured person and determining the necessary level of care and treatment as a method of controlling health care costs. Each case is reviewed at reasonable intervals.

Activities of Daily Living

Long-term care benefits triggers are defined by federal law and must be used in qualified policies:

- Disability is measured in terms of the insured's ability to perform, without substantial human assistance from another individual, the activities of daily living, which includes eating, bathing, using the toilet, dressing, continence, and getting in or out of bed.
- Cognitive impairment is the loss of abstract reasoning that results in an individual needing supervision and /or assistance.

A **plan of care** is a document prepared by a physician or licensed social worker and a registered nurse, specifying the prescribed long-term care services or treatment consistent with the patient's conditions and abilities. The plan must include services that could not be omitted without adversely affecting the patient's condition.

Elimination Period

The **elimination period** is the period of time after the onset of a loss during which benefits are not paid. The longer the elimination period, the lower the premium rate.

In Connecticut, the elimination period in a long-term care policy cannot be more than **100 days** of confinement.

Marketing Methods and practices

Solicitation

Long-term care insurers must establish marketing procedures to ensure that

- Any comparison of policies by their producers will be fair and accurate;
- Excessive insurance is not sold to any individual;
- Producers will determine whether applicants have existing long-term care coverage;
- Applicants will be notified of the existence of any state sponsored insurance counseling programs; and
- Twisting, high-pressure sales tactics and cold lead advertising will not be used.

Copyright © 2021 ExamFX

The first page of the outline of coverage and the policy must contain a **Notice to Buyer** which explains that the policy may not cover all of the costs associated with long-term care during the coverage period, and advising the buyer to review the policy limitations.

Requirements for Small Employers

Special Provisions

There are several plans that may be offered to small employers. They include the following:

- Basic hospital plan;
- Basic surgical plan;
- Supplemental major medical plan (written in conjunction with a basic plan);
- Comprehensive major medical plan; and
- PPO plan.

Disclosure Requirements

A small employer carrier must quote premium rates to any small employer within 30 days after receipt of the employer's completed application. Carriers cannot disclose to a small employer the fact that any of the eligible employees of that small employer have been reinsured with the Connecticut Small Employer Health Reinsurance Pool.

Connecticut Comprehensive Health Care Plan

Prior to the implementation of the Affordable Care Act, every carrier that was offering individual health insurance in Connecticut or every hospital or a medical service corporation that chose not to participate in the HRA, was required to make *an individual comprehensive health care plan* available to every resident of the state, except for residents who are both 65 years of age or older and eligible for Medicare, as a condition of transacting health insurance. Carriers that provided group health insurance were required to make a *group comprehensive health care plan*.