

**State of Connecticut
Regulation of
Insurance Department
Concerning
Group Health, Drug Formulary, and Small Employer Group Health Rate Review**

Section 1. Section 38a-481-1 and 38a-481-9 of the Regulations of Connecticut State Agencies are amended to read as follows:

Sec. 38a-481-1. Definitions

As used in Sections 38a-481-1 to [38a-481-9] 38a-481-13, inclusive, of the Regulations of Connecticut State Agencies, unless the context otherwise requires:

- (1) “Commissioner” means the Insurance Commissioner of the State of Connecticut.
- (2) “Department” means the Connecticut Insurance Department.
- (3) “Excessive rate” means the rate is unreasonably high for the insurance provided.
- (4) “Experience period” means the most recent [twelve-month] twelve (12) month period from which the insurer accumulates the data to support a rate filing.

(5) “Form” means a policy of insurance against loss or expense from sickness, or from bodily injury or death by accident, or application, rider or endorsement used in connection therewith.

(6) “Formulary” means a list of prescription drugs that are covered by a specific health insurance plan.

[(6)](7) “Inadequate rate” means a rate that is unreasonably low for the insurance provided, and continued use of it would endanger solvency of the insurer.

[(7)](8) “Insurer” means a health care center, as defined in Section 38a-175 of the Connecticut General Statutes, or an insurance company licensed by the Commissioner to write accident and health insurance.

[(8)](9) “Loss ratio” has the same meaning as provided in Section 38a-481(a) of the Connecticut General Statutes.

(10) “Pharmaceutical and therapeutics committee” or “P&T committee” means a group of members that may include physicians, pharmacists, administrators, quality improvement managers, other health care professionals and staff appointed by an insurer to establish policies regarding the use of drugs, therapies and drug-related products, identifying those that are most medically appropriate.

[(9)](11) “PPACA” means Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(12) “Prescription drug tier” means a subset of the drugs covered in a formulary that are covered and subject to a specified level of cost share.

[(10)](13) “SERFF” means the National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing.

(14) “Specialty drug” means a unique prescription drug that may require special handling, close monitoring or may only be available from limited pharmacies.

[(11)](15) “Unfairly discriminatory” means rating practices that reflect differences based on age, disability, race, ethnicity, gender, sexual orientation or health status that are not actuarially justified or otherwise prohibited by law.

[(12)] (16) “Utilization data” means the number of services used by a fixed number of covered

persons, as defined in Section 38a-591a of the Connecticut General Statutes, over a fixed length of time.

Sec. 38a-481-9. Additional rate filing requirements

(a) All rate filings for individual health insurance providing coverage of the types specified in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) shall include:

(1) A demonstration that the experience data submitted is consistent with the most recent financial statement filed by the insurer with the Department pursuant to section 38a-53a of the Connecticut General Statutes.

(2) Utilization trend by broad service category, including utilization data.

(3) Impact of cost sharing leverage on trend.

(4) Medical technology trend.

(5) Benefit buy-down analysis and impact on trend.

(6) Cost of each new benefit mandate or requirement due to a change in state or federal law, separately identified, from the experience period to the rating period.

(7) Unit cost trend by broad service category, including actual unit cost data and impact of provider contract changes from experience period to rating period (medical and prescription drug separately).

(8) An annual certification of compliance with mental health parity. Any insurer that offers a plan that includes a cost share for medical expense at a lower level than the mental health cost share shall include [For plans that have a copayment for a mental health office visit set at the specialist level,] a demonstration that the copayment is in compliance with mental health parity [shall also be filed].

(9) A certification and demonstration that any substitution of a non-dollar limit on an essential health benefit as permitted by the PPACA is actuarially justified.

(10) A comparison of the proposed retention charge in the filing to the most recently filed financial statement for the insurer for which this filing is being made.

(11) Monthly historical experience including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios shall be provided for the most recent two (2) years.

(12) The current capital and surplus for the insurer for which this filing is being made.

(13) For filings subject to the PPACA, a demonstration that the rate increase requested in this filing will generate an expected medical loss ratio, for rebate purposes, that is consistent with the medical loss ratio prescribed by the federal law for individual health insurance.

(14) For filings subject to the PPACA, the Uniform Rate Review Template (URRT), the Part III Actuarial Memorandum, and the Health Insurance Oversight System rate tables. The Health Insurance Oversight System rate tables shall be filed in a portable document format. Insurers shall also provide a summary of benefits for each plan design along with the federal Department of Health and Human Services' Actuarial Value Calculator output that confirms compliance with the corresponding metal tier set forth in the PPACA. The Health Insurance Oversight System plan ID and the corresponding plan name on the summary of benefits for each plan shall be indicated.

(b) Every rate filing submission for individual health insurance providing coverage of the types specified in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) that includes an increase to previously approved rates shall include a summary of the rate increases requested and shall be clearly marked as Appendix A. The appendix shall include, but not be limited to, the following:

(1) The requested rate increase for each product contained within the rate filing and the effective date of each proposed rate increase. The requested increase for each product shall be identified as a specific percent increase or, if appropriate, a range of percent increases with an explanation of what

the variance is that produces the range.

(2) Number of covered individuals for each product; number of covered policyholders; minimum current premium on a per member per month (pmpm) basis; minimum proposed premium on a pmpm basis; maximum current premium on a pmpm basis; maximum proposed premium on a pmpm basis and the percentage change.

(3) Each component of the rate increase including trend, experience adjustments and any other factors that are a component of the requested rate increase. These may be identified as a specific percent or, if appropriate, a percent range.

(4) A footnote listing any other factors that can have an impact on premium rates that have not been specifically identified in the appendix, including, but not limited to, age bands, [gender,] geographic area, and smoking.

Sec. 2. The Regulations of Connecticut State Agencies are amended by adding sections 38a-481-10 to 38a-481-13, inclusive, as follows:

(NEW) Sec. 38a-481-10. Formulary annual filing requirements

Insurers that deliver, issue for delivery, renew, amend or continue any individual health insurance policy that includes prescription drug coverage and utilizes a formulary shall submit an annual report to the Commissioner regarding the development and use of formularies and P&T committees. Such report shall be in a form prescribed by the commissioner and shall be submitted with the annual form filing.

(NEW) Sec. 38a-481-11. Minimum standards for formularies

No individual health insurance policy that offers prescription drug coverage that is subject to a formulary shall be delivered or issued for delivery in this state if the formulary does not meet the following required minimum standards:

- (1) The formulary shall be easily searchable and posted online, accessible to members and non-members.
- (2) The medications within the formulary shall be grouped in alphabetical order by therapeutic class.
- (3) Definitions or explanations, or both, of each prescription drug tier, including specialty drug tiers, shall be clearly stated.
- (4) Definitions for utilization controls, including, but not limited to, quantity or dosage controls, prior authorization, and step therapy shall be clearly stated.
- (5) Tier coverage and utilization controls for each medication (by dosage, if applicable) shall be clearly stated.
- (6) The formulary shall include information on how to obtain drugs that are off formulary.
- (7) The formulary shall specify if and how drugs may be obtained through mail order pharmacy.
- (8) The formulary shall clearly state when it was created, when it was last updated, and when the next anticipated update will be.
- (9) The formulary shall provide customer service contact information.
- (10) The formulary shall meet all additional requirements as set by the Commissioner.

(NEW) Sec. 38a-481-12. Minimum standards for pharmaceutical and therapeutics committees

- (a) (1) No insurer shall utilize a P&T committee that does not have appropriate membership.
- (A) A majority of P&T committee members shall be practicing physicians, pharmacists, and other professionals who are licensed to prescribe drugs.
- (B) P&T committee members shall represent a sufficient number of clinical specialties to

adequately meet the needs of enrollees.

(2) Insurers shall put in place a process to ensure that there is no conflict of interest among members of the P&T committee with respect to the issuer or any pharmaceutical manufacturer. The process shall include an explanation of how conflicts of interest are dealt with if they arise.

(3) Insurers shall put in place a process to ensure that P&T committee members abstain from voting if there is a conflict of interest.

(b) The P&T committee shall meet regularly.

(1) Insurers shall put in place a process, including timeframes, to ensure that the P&T committee meets and makes decisions on new FDA-approved drugs within a reasonable time frame after the drug is released into the market.

(2) The P&T committee shall meet at least quarterly and maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary.

(3) The P&T committee shall evaluate and analyze treatment protocols and procedures related to the plans' formulary at least annually.

(c) Insurers shall develop and document procedures to ensure appropriate formulary drug review and inclusion.

(1) Insurers shall provide a copy of the policies and procedures in place to ensure that the P&T committee:

(A) Bases clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information.

(B) Considers the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(C) Reviews new FDA-approved drugs and new FDA-approved uses for existing drugs.

(D) Reviews policies that guide exceptions and other utilization management processes, including, but not limited to, drug utilization review, quantity limits, prior authorizations, step therapies, generic substitutions, and therapeutic interchange.

(2) Insurers shall provide information on how often the formulary is updated on the company website and whether timeframes vary depending on whether the changes are advantageous to the enrollee.

(3) Insurers shall develop a process to ensure the formulary recommended by the P&T committee:

(A) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommends drug treatment regimens that treat all disease states.

(B) Does not discourage enrollment of any group of enrollees through discriminatory tiering and utilization management processes.

(C) Includes multiple drugs, strengths and dosage forms for each therapeutic class and, if multiple drugs are available to treat a disease, they are not all placed in the highest cost share tier.

(D) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time and based on use of a tool set forth by the Commissioner.

(NEW) Sec. 38a-481-13. Notice to insureds regarding formulary changes

Insurers that deliver, issue for delivery, renew, amend or continue any individual health insurance policy that includes prescription drug coverage and utilizes a formulary shall provide at least sixty (60) days' advance notice to each insured under the policy utilizing a prescription drug within the formulary before the insurer may remove such prescription drug from the formulary or make any change to the structure of prescription drug benefits under such policy.

Sec. 3. Section 38a-513-1 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-513-1. [Group specified disease policies] Definitions

As used in sections 38a-513-1 to 38a-513-13, inclusive, of the Regulations of Connecticut State Agencies, unless otherwise provided:

[(a)] [A “group specified disease policy” means a group health insurance policy or certificate delivered or issued for delivery in this state which pays benefits for the diagnosis or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38-513-1(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 group 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 group specified disease policies in addition to all other requirements applicable to group accident and sickness policies.

(1) Group policies covering a single specified disease, condition, or syndrome or combination of specified diseases, conditions, or syndromes may not be sold or offered for sale other than as group specified disease policies.

(2) Any group specified disease policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, condition or syndrome, 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, group specified disease policies described in section 38a-513-1(c) (1) and section 38a-513-1(c) (2) of the Regulations of Connecticut State Agencies shall provide benefits to any covered certificate holder not only for a specified disease, condition or syndrome but also for any other disease, condition or syndrome, directly caused or aggravated by the specified disease, condition or syndrome or its treatment.

(4) All group specified disease policies shall include a provision which allows the certificate holder to continue coverage or convert to an individual specified disease policy in the event of termination of the eligibility of the certificate holder or in the event of the cancellation, nonrenewal or termination of the group specified disease policy. Conversion is to be made without evidence of insurability and without pre-existing conditions limitations or waiting periods, with an effective date that coincides with the date coverage ceased under the group plan.

(5) No group specified disease policy issued pursuant to this section shall contain a waiting or probationary period greater than thirty (30) days. Premiums paid for a certificate holder shall be refunded if the certificate holder is diagnosed with a covered disease, condition or syndrome during the waiting or probationary period. Alternatively, the certificate may provide for an additional option for the certificate holder to continue the certificate in force, but in no event shall benefits for that disease, condition or syndrome be withheld beyond the time period specified in the pre-existing condition provision.

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

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

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

(9) Benefit payments under group specified disease policies described in section 38a-513-1(c) (1) and section 38a-513-1(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 disease, condition or syndrome even though the diagnosis of a covered disease, condition or syndrome 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 disease, condition or syndrome.

(10) Group 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 and certificate in bold face equal to at least fourteen (14) point type.

(11) Group specified disease policies and certificates shall contain a prominent statement on the first page of the policy and certificate in bold face type at least equal to fourteen (14) point type as follows: “CAUTION! This policy (or certificate) PROVIDES LIMITED COVERAGE. IT IS NOT A MAJOR MEDICAL POLICY (OR CERTIFICATE). Read it carefully. It only pays benefits for treatment (or diagnosis) of (specified disease, condition or syndrome).”

(12) The premiums for a group specified disease policy shall be reasonable in relation to benefits and shall not be excessive or inadequate. The insurer shall establish premiums for group specified disease policies in accordance with generally accepted actuarial principles and practices so as to return to certificate holders in the form of aggregate benefits provided under the policy during the period for which rates are computed at least sixty five percent (65%) of the aggregate premiums earned. Each insurer shall annually report by June 30 earned premiums and incurred claims for the prior calendar year for each approved group 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 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 certificate holder. No policy shall exclude for a loss due to a preexisting condition for a period greater than twelve (12) months following the certificate holder’s effective date of coverage.

(c) Each group specified disease policy shall meet the minimum benefit standards provided in subdivision (1), (2) or (3) of this subsection. In addition, a group 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 group specified disease policy, except that group specified disease 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 certificate holder insured under the policy for one or more specifically named diseases, conditions or syndromes, with a deductible amount not in excess of one thousand dollars (\$1,000), co-insurance by the insured not to exceed twenty five per cent (25%), and an overall aggregate lifetime benefit limit, per certificate holder, of not less than two hundred and fifty thousand dollars (\$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) eighty per cent (80%) of the reasonable charges, or (ii) fifteen percent (15%) of the surgical service benefit;
 - (L) Home health care as described in section 38a-520(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
 - (S) Any other expenses necessarily incurred in the care and treatment of the covered condition.
- (2) Per diem indemnification for each certificate holder 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 two hundred and fifty thousand dollars (\$250,000) while medically confined, subject to the following minimum benefit standards:
- (A) A fixed-sum payment of at least one hundred and fifty dollars (\$150) for each day of hospital confinement;
 - (B) A fixed-sum payment equal to at least one hundred dollars (\$100) 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, and home health care for at least one hundred (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, condition, or syndrome of not less than one thousand dollars (\$1,000). In addition, payment amounts may be limited to not less than two hundred and fifty dollars (\$250) for one or more specified diseases, conditions, or syndromes where coverage is provided under such policy for two or more specified diseases, conditions, or syndromes, provided that the aggregate amount payable under the policy for all specified diseases, conditions, or syndromes is at least one thousand dollars (\$1,000). Also, coverage for a fixed-sum payment for a spouse or dependent may be included under the policy, provided the benefit amount included is at least twenty-five per cent (25%) of the benefit amount for the certificate holder. Where coverage is advertised or otherwise represented to offer generic coverage of a specified disease, condition, or syndrome, the same dollar amounts shall be payable, regardless of the particular subtype of the disease, condition, or syndrome unless such subtype is clearly identifiable and the policy clearly differentiates that subtype and its benefits.
- (d) No group 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 certificate.

The items included in the outline of coverage shall appear in the sequence prescribed below:

CAUTION!

(COMPANY NAME)

(SPECIFIED DISEASE, CONDITION OR SYNDROME) COVERAGE

OUTLINE OF COVERAGE

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

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

(3) This certificate is NOT A MEDICARE SUPPLEMENT certificate. 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 certificate.)

(5) (A description of any certificate 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 certificate provisions respecting continuation or conversion of coverage in the event of group policy termination.)]

(1) “Activities of daily living” means activities such as bathing, dressing, eating, toileting, and transferring.

(2) “Commissioner” means the Insurance Commissioner of the State of Connecticut.

(3) “Department” means the Connecticut Insurance Department.

(4) “Excessive rate” means the rate is unreasonably high for the insurance provided.

(5) “Experience period” means the most recent twelve (12) month period from which the insurer accumulates the data to support a rate filing.

(6) “Form” means a policy or certificate of insurance against loss or expense from sickness, or from bodily injury or death by accident, or application, rider or endorsement used in connection therewith.

(7) “Formulary” means a list of prescription drugs that are covered by a specific health insurance plan.

(8) “Group specified disease policy” means a group health insurance plan or certificate delivered or issued for delivery in this state which pays benefits for the diagnosis or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38a-513-4(g)(13) of the Regulations of Connecticut State Agencies.

(9) “Health insurance plan” has the same meaning as provided in Section 38a-564 of the Connecticut General Statutes.

(10) “Inadequate rate” means a rate that is unreasonably low for the insurance provided, and continued use of it would endanger solvency of the insurer.

(11) “Insurer” means a health care center, as defined in Section 38a-175 of the Connecticut General Statutes, or an insurance company licensed by the Commissioner to write accident and health insurance.

(12) “Loss ratio” has the same meaning as provided in Section 38a-481(a) of the Connecticut General Statutes.

(13) “One period of confinement” means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred and eighty (180) days.

(14) “Pharmaceutical and therapeutics committee” or “P&T committee” means a group of members that may include physicians, pharmacists, administrators, quality improvement managers, other health care professionals and staff appointed by an insurer to establish policies regarding the use of drugs, therapies and drug-related products, identifying those that are most medically appropriate and cost effective.

(15) “PPACA” means Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and regulations adopted thereunder.

(16) “Prescription drug tier” means a subset of the drugs covered in a formulary that are covered and subject to a specified level of cost share.

(17) “SERFF” means the National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing.

(18) “Small employer” has the same meaning as provided in Section 38a-564 of the Connecticut General Statutes.

(19) “Specialty drug” means a unique prescription drug that may require special handling, close monitoring or may only be available from limited pharmacies.

(20) “Unfairly discriminatory” means rating practices that reflect differences based on age, disability, race, ethnicity, gender, sexual orientation or health status that are not actuarially justified or are otherwise prohibited by law.

(21) “Utilization data” means the number of services used by a fixed number of covered persons, as defined in Section 38a-591a of the Connecticut General Statutes, over a fixed length of time.

Sec. 4. The Regulations of Connecticut State Agencies are amended by adding sections 38a-513-2 to 38a-513-14, inclusive, as follows:

(NEW) Sec. 38a-513-2. Group health prohibited policy provisions

(a) Except as provided in section 38a-513-4(g)(4), no policy or certificate shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy or certificate except the policy or certificate may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproductive organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(b) No policy or certificate shall exclude coverage for a loss due to a pre-existing condition for a period greater than twelve (12) months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment.

(c) A disability income policy or certificate may contain a “return of premium” or “cash value benefit” so long as:

(1) The insurance policy is non-cancellable or, if the benefit is added by rider, it is attached to a non-cancellable policy.

(2) The forms provide for the payment of surrender value upon:

(A) The written request of the insured, and surrender of the policy or certificate,

(B) Lapse of the policy or certificate,

(C) Death of the insured, or

(D) On the termination date of the contract.

(3) The surrender value is based on policy duration, premiums paid by the insured and benefits paid by the company and a refund is available after a certificate has been in force for a minimum of three (3) years (two (2) years on certificates issued on insureds forty-six (46) to fifty (50) years old).

(4) The form is not issued beyond age fifty (50).

(5) The insurer includes a detailed statement of the method of computing the premium rates, the tables of cash value, and the estimated loss ratio.

(6) The insurer includes a demonstration of the fiscal integrity of the product and the company.

(7) The form is not on the basis of the ten (10) year roll-over concept.

(d) No other policy or certificate shall provide a return of premium or cash value benefit, except returned or unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

(e) Policies or certificates providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(f) No policy or certificate shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) Pre-existing conditions or diseases where permitted, except for congenital anomalies of a covered dependent child;

(2) Mental or emotional disorders, alcoholism and drug addiction, except as set forth in section 38a-514 of the Connecticut General Statutes;

(3) Pregnancy, except for complications of pregnancy, other than for policies described in section 38a-513-4(c) of the Regulations of Connecticut State Agencies;

(4) Illness, treatment or medical condition arising out of:

(A) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the Armed Forces or units auxiliary thereto;

(B) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(C) Aviation;

(D) With respect to short-term renewable policies, inter-scholastic sports;

(5) Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

(6) Treatment provided in a government hospital, benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employers' liability or occupational disease law, or the basic reparations benefits of any motor vehicle no-fault law, services rendered by employees of hospitals, laboratories or other institutions, services performed by a member of the insured person's immediate family and services for which no charge is normally made in the absence of insurance;

(7) Dental care or treatment except as set forth in sections 38a-517, 38a-517a, and 38a-517b of the Connecticut General Statutes;

(8) Eye glasses, hearing aids and examination for the prescription or fitting thereof, except as set forth in section 38a-516b of the Connecticut General Statutes;

(9) Rest cures, custodial care, transportation and routine physical examinations; and

(10) Territorial limitations.

(g) Policy provisions precluded in this section shall not be construed as a limitation on the

authority of the Commissioner to disapprove other policy provisions in accordance with section 38a-513 of the Connecticut General Statutes that, in the opinion of the Commissioner, are unjust, unfair, or deceptive, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy or that encourage misrepresentation of the policy.

(NEW) Sec. 38a-513-3. Minimum standards for group health insurance benefits

The following minimum standards for benefits are prescribed for the categories of coverage noted in subsections (a) to (g), inclusive, of this section. No such group policy or certificate shall be delivered or issued for delivery in this state that does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies or contracts are approvable as limited benefit health insurance. Nothing in this section shall preclude the issuance of any policy or contract combining two or more categories of coverage.

(a) General Rules.

(1) A “non-cancellable,” “guaranteed renewable,” or “non-cancellable and guaranteed renewable” policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than non-payment of premium. The policy shall provide that in the event of the insured’s death the spouse of the insured, if covered under the policy, shall become the insured.

(2) The terms “non-cancellable,” “guaranteed renewable,” or “non-cancellable and guaranteed renewable” shall not be used without further explanation. The terms “non-cancellable” or “non-cancellable and guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to unilaterally make any change in any provision of the policy while the policy is in force. Any accident and health or accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively or regularly employed. Except as provided above, the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to unilaterally make any change in any provision of the policy while the policy is in force, except as mandated by statute and except that the insurer may make changes in premium rates by classes. Any accident and health or accident only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed.

(3) If a policy contains a status type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

(4) In the event an insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to a pregnancy that commences while the policy is in force and for which benefits would have been payable had the policy remained in force.

(5) Policies providing convalescent or extended care benefit following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

(6) Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental or physical handicap on the date that such child’s coverage would

otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of such date the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

(7) Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

(8) A policy may contain a provision relating to recurrent disabilities, except that no such provision shall specify that a recurrent disability be separated by a period of greater than six (6) months.

(9) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days after the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(10) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(11) Any accident only policy providing benefits that vary according to the type of accidental cause shall prominently describe the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(12) Termination of the policy shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(b) "Hospital Confinement Indemnity Coverage" is a policy or certificate that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than thirty dollars (\$30) per day and not less than thirty-one (31) days during any one period of confinement for each person insured under the policy.

(c) "Disability Income Protection Coverage" is a policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof that:

(1) Provides that periodic payments that are payable at ages after age sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to age sixty-two (62).

(2) Contains an elimination period no greater than:

(A) Ninety (90) days in the case of a coverage providing a benefit period of one (1) year or less;

(B) One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years, or

(C) Three hundred and sixty-five (365) days in all other cases during the continuance of disability resulting from sickness or injury.

(3) Has a maximum period of time for which it is payable during disability of at least six (6) months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be one (1) month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. This section does not apply to those policies providing business buyout coverage.

(d) "Accident Only Coverage" is a policy or certificate that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least one

thousand dollars (\$1,000) and a single dismemberment amount shall be at least five hundred dollars (\$500).

(e) “Specified Accident Coverage” is a policy or certificate that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than one thousand dollars (\$1,000) for accidental death; one thousand dollars (\$1,000) for double dismemberment and five hundred dollars (\$500) for single dismemberment.

(f) “Limited Benefit Health Insurance Coverage” is any policy or certificate that covers all of the minimum standards of a category of the type specified in subdivisions (1), (2), (3), (4), (5), (6), and (8) of section 38a-469 of the Connecticut General Statutes but at a lower level of coverage.

(g) “Specified Disease Coverage” is a policy or certificate delivered or issued for delivery in this state that pays benefits for the diagnosis or treatment of one or more specifically named diseases, conditions or syndromes in accordance with section 38a-513-4(g)(13) of the Regulations of Connecticut State Agencies.

(h) “Accident,” “Accidental Injury,” or “Accidental Means” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization. The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person that are the direct cause, independent of disease or bodily infirmity or any other cause and occur while the insurance is in force. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers’ compensation, employers’ liability or similar law, the basic reparations benefits of any motor vehicle no-fault plan or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(i) “Condition” includes specifically named diseases, conditions or syndromes unless the context otherwise requires.

(j) “Convalescent Nursing Home,” “Extended Care Facility,” or “Skilled Nursing Facility” shall be defined in relation to its status, facilities, and available services.

(1) A definition of such home or facility shall not be more restrictive than one requiring that it:

(A) Be operated pursuant to law;

(B) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(C) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(D) Provide continuous twenty-four (24) hours a day nursing service by or under the supervision of a registered nurse;

(E) Maintain a daily medical record of each patient.

(2) The definition of such home or facility may provide that such term shall not be inclusive of:

(A) Any home, facility or part thereof used primarily for rest;

(B) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(C) A home or facility primarily used for the care and treatment of mental diseases or disorders or custodial or educational care.

(k) “Hospital” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

(1) The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital:

(A) Be an institution operated pursuant to law; and

(B) Be primarily and continuously engaged in providing or operating either on its premises or in

facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

(C) Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term “hospital” may state that such term shall not be inclusive of:

(A) Convalescent homes, convalescent, rest, or nursing facilities; or

(B) Facilities primarily affording custodial, educational or rehabilitative care; or

(C) Facilities for the aged, drug addicts or alcoholics; or

(D) Any military or veterans’ hospital or soldiers’ home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or former members of the Armed Forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(I) “Medicare” shall be defined in any hospital, surgical or medical expense policy that relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof” or words of similar import.

(m) “Nurses” may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse or licensed practical nurse. If the words “nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(n) “Partial Disability” shall be defined in relation to the individual’s inability to perform one or more, but not all, of the “major,” “important,” or “essential” duties of his employment or occupation or may be related to a “percentage” of time worked or to a “specified number of hours” or to “compensation.” Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required.

(o) “Physician” shall be defined as a person who is licensed by the state in which he or she practices to give treatment for which benefits are provided under the policy and who is acting within the scope of his or her license.

(p) “Pre-existing condition” shall not be defined to be more restrictive than the following: Pre-existing condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five (5) year 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 five (5) year period preceding the effective date of the coverage of the insured person. This definition does not prohibit an insurer, using an application form designated to elicit the complete health history of a prospective insured and on the basis of the answers on that application, from underwriting in accordance with that insurer’s established standards. It is assumed that an insurer that elicits a complete health history of a prospective insured will act on the information and if the review of the health history results in a decision to exclude a condition, the policy will be endorsed or amended by including the specific exclusion. This same requirement of notice to the prospective insured of the specific exclusion will also apply to insurers that elect to use simplified application forms containing questions relating to the prospective insured’s health. This definition does, however, prohibit an insurer that elects to use a simplified application, with or without a question as to the applicant’s health at the time of application, from reducing or denying a claim on the basis of the existence of a pre-existing condition

that is defined more restrictively than above.

(q) “Residual Disability” shall be defined in relation to the individual’s reduction in earnings and may be related either to the inability to perform some part of the “major,” “important,” or “essential duties” of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured person must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term “residual disability,” the insurer may use “proportionate disability” or other term of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

(r) “Sickness” shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period that shall not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability or similar law.

(s) (1) “Total Disability” shall not be defined more restrictively than to mean an individual who is (A) totally disabled from engaging in any employment or occupation for which such individual is, or becomes, qualified by reason of education, training or experience, and (B) not engaged in any employment or occupation for wage or profit.

(2) “Total disability” may be defined in relation to the inability of an individual to perform duties, but may not be based solely upon an individual’s inability to (A) perform any occupation whatsoever, any occupational duty, or any and every duty of such individual’s occupation, or (B) engage in any training or rehabilitation program. An insurer may require that an individual be completely unable to perform all of the substantial and material duties of such individual’s regular occupation to be totally disabled, and may require that an individual receive care from a physician who is not the insured or a member of the insured’s immediate family.

(NEW) Sec. 38a-513-4. Required provisions for group health insurance benefits

(a) General Rules.

(1) Each group policy or certificate of accident and sickness insurance shall include a renewal, continuation, or non-renewal provision. The language or specifications of such provision shall be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder, or exercises a specifically reserved right under the policy or certificate, all riders or endorsements added to a policy or certificate after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy or certificate shall require signed acceptance by the policyholder. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the policyholder, except if the increase in benefit or coverage is required by law.

(3) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy or certificate.

(4) A policy or certificate that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” “maximum allowable charge,” or words of similar import shall include a definition of such terms and an explanation of such terms.

(5) If a policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and be labeled as “Pre-existing Conditions Limitations.”

(6) All accident only policies shall contain a prominent statement on the first page or an attachment to the policy and certificate in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: “This is an accident only policy and it does not pay benefits for loss from sickness.”

(7) If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be “Conversion Privilege” or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(b) Hospital confinement indemnity policies or certificates are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits that are described pursuant to subdivision (4) of this subsection. The policy or certificate shall include:

(1) A clear and concise description of the benefits including a description of any deductible, coinsurance or co-payment provisions applicable to the benefits described, and proper disclosure of benefits that vary according to accidental cause and also including:

(A) Daily benefit payable during hospital confinement; and

(B) Duration of the benefit described in subparagraph (A) of this subdivision.

(2) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described pursuant to subdivision (1) of this subsection.

(3) A description of policy provisions regarding renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(4) Any benefits provided in addition to the daily hospital benefit.

(c) Disability income protection policies or certificates are designed to provide, to persons insured, income protection coverage in the form of periodic payments for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses. The policy or certificate shall include:

(1) A clear and concise description of the benefits including a description of any deductible, coinsurance or co-payment provisions applicable to the benefits described, and proper disclosure of benefits that vary according to accidental cause.

(2) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described pursuant to subdivision (1) of this subsection.

(3) A description of policy provisions regarding renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(d) Accident only policies or certificates are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident only, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses. The policy or certificate shall include:

(1) A clear and concise description of the benefits including a description of any deductible, coinsurance or co-payment provisions applicable to the benefits described, and proper disclosure of benefits that vary according to accidental cause.

(2) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described pursuant to subdivision (1) of this subsection.

(3) A description of policy provisions regarding renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(e) Specified accident policies or certificates are designed to provide, to persons insured, restricted coverage paying benefits only when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expense. The policy or certificate shall include:

(1) A clear and concise description of the benefits including a description of any deductible, coinsurance or co-payment provisions applicable to the benefits described, and proper disclosure of benefits that vary according to accidental cause.

(2) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described pursuant to subdivision (1) of this subsection.

(3) A description of policy provisions regarding renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(f) Limited benefit policies or certificates are designed to provide to the person insured all of the benefits of a category of the type specified in subdivisions (1), (2), (3), (4), (5), (6), and (8) of section 38a-469 of the Connecticut General Statutes but at a lower level of coverage. The policy or certificate shall include:

(1) A clear and concise description of the benefits including a description of any deductible, coinsurance or co-payment provisions applicable to the benefits described, and proper disclosure of benefits that vary according to accidental cause.

(2) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described pursuant to subdivision (1) of this subsection.

(3) A description of policy provisions regarding renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(g) Specified disease policies or certificates are designed to provide to the person insured benefits for the diagnosis and treatment of one or more specifically named diseases, conditions or syndromes. As used in this section, “condition” includes specifically named diseases, conditions or syndromes unless the context otherwise requires. The following requirements shall apply to group specified disease policies in addition to all other requirements applicable to group accident and sickness policies.

(1) Any specified disease policy or certificate that conditions payment upon pathological diagnosis of a covered disease, condition or syndrome shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis shall be accepted in lieu thereof.

(2) Policies and certificates described in subdivision (13) of this subsection shall provide benefits to any covered certificate holder not only for a specified disease, condition or syndrome, but also for any other disease, condition or syndrome directly caused or aggravated by the specified disease, condition or syndrome or its treatment.

(3) All policies and certificates shall include a provision that allows the certificate holder to continue coverage or convert to an individual specified disease policy in the event of termination of the eligibility of the certificate holder or in the event of the cancellation, nonrenewal or termination of

the group specified disease policy. Conversion shall be made without evidence of insurability and without pre-existing conditions limitations or waiting periods, with an effective date that coincides with the date coverage ceased under the group plan.

(4) No specified disease policy or certificate shall contain a waiting or probationary period greater than thirty (30) days. Premiums paid for a certificate holder shall be refunded if the certificate holder is diagnosed with a covered disease, condition or syndrome during the waiting or probationary period. Alternatively, the certificate may provide for an additional option for the certificate holder to continue the certificate in force, but in no event shall benefits for that disease, condition or syndrome be withheld beyond the time period specified in the pre-existing condition provision.

(5) Payment of benefits may be conditioned upon a covered certificate holder receiving medically necessary care or treatment.

(6) Any application for a specified disease policy or certificate shall contain a prominent statement above the signature of the applicant that a person who is already covered by Medicaid is not eligible for this coverage and cannot be included in the group. Such statement shall be in bold face type or contrasting color.

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

(8) Benefit payments under group specified disease policies described in subdivision (14) of this subsection 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 disease, condition or syndrome even though the diagnosis of a covered disease, condition or syndrome 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 disease, condition or syndrome.

(9) Specified disease policies and certificates 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 and certificate in bold face equal to at least fourteen (14) point type.

(10) Specified disease policies and certificates shall contain a prominent statement on the first page of the policy and certificate in bold face type at least equal to fourteen (14) point type as follows: “CAUTION! This policy (or certificate) PROVIDES LIMITED COVERAGE. IT IS NOT A MAJOR MEDICAL POLICY (OR CERTIFICATE). Read it carefully. It only pays benefits for treatment (or diagnosis) of (specified disease, condition or syndrome).”

(11) The premiums for a specified disease 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 certificate holders in the form of aggregate benefits provided under the policy during the period for which rates are computed at least sixty-five percent (65%) of the aggregate premiums earned. Each insurer shall annually report by June 30 earned premiums and incurred claims for the prior calendar year for each approved group specified disease policy form in a format acceptable to the Commissioner.

(12) “Pre-existing condition” shall not be defined in a group specified disease policy to be more restrictive than the following: Pre-existing condition means 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 certificate holder. No policy or certificate shall exclude for a loss due to a pre-existing condition for a period greater than twelve (12) months following the certificate holder’s effective date of coverage.

(13) Each specified disease policy and certificate shall meet the minimum benefit standards provided in subparagraph (A), (B) or (C) of this subdivision. In addition, a specified disease policy may combine coverages of the types described in subparagraph (A), (B), and (C) of this subdivision.

A policy that combines coverages and meets the minimum benefit standard requirements set forth in subparagraph (A), (B), or (C) of this subdivision may be approved for sale in the state if it includes some, but not all, of the benefits otherwise permitted by another type of group specified disease policy, except that group specified disease policies combining coverage of the types described in subparagraph (A) and (B) of this subdivision shall meet the minimum requirements for each type of coverage.

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

- (i) Hospital room and board and hospital furnished medical services or supplies;
- (ii) Treatment by, or under the direction of, a physician or surgeon;
- (iii) Private duty services of a registered nurse or a licensed practical nurse;
- (iv) X-ray, radium, cobalt, nuclear medicine, chemotherapy, and other therapeutic procedures used in diagnosis and treatment;
- (v) Licensed ambulance for local service to or from a local hospital;
- (vi) Blood transfusions, and plasma, and the administration thereof;
- (vii) Drugs and medicines prescribed by a physician;
- (viii) The rental of any respirator or other mechanical apparatus;
- (ix) Braces, crutches, wheelchairs and other adaptive devices deemed necessary by the attending physician because of the incapacitating nature of the covered condition;
- (x) Transportation beyond the local area for medically necessary treatment;
- (xi) 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) eighty percent (80%) of the reasonable charges, or (II) fifteen percent (15%) of the surgical service benefit;
- (xii) Home health care as described in section 38a-520(d) of the Connecticut General Statutes;
- (xiii) Physical, speech, hearing and occupational therapy for symptoms related to the covered condition;
- (xiv) 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;
- (xv) Reconstructive surgery when medically necessary;
- (xvi) Prosthetic devices including wigs and artificial breasts;
- (xvii) Nursing home care;
- (xviii) Hospice care; and
- (xix) Any other expenses necessarily incurred in the care and treatment of the covered condition.

(B) Per diem indemnification for each certificate holder 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 two hundred and fifty thousand dollars (\$250,000) while medically confined, subject to the following minimum benefit standards:

- (i) A fixed-sum payment of at least one hundred and fifty dollars (\$150) for each day of hospital confinement;
- (ii) A fixed-sum payment equal to at least one hundred dollars (\$100) for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy; and
- (iii) A fixed-sum payment equal to one-half of the hospital in-patient benefit for each day of

nursing home care, hospice care, and home health care for at least one hundred (100) days.

(C) 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, condition, or syndrome of not less than one thousand dollars (\$1,000). In addition, payment amounts may be limited to not less than two hundred and fifty dollars (\$250) for one or more specified diseases, conditions, or syndromes where coverage is provided under such policy for two or more specified diseases, conditions, or syndromes, provided that the aggregate amount payable under the policy for all specified diseases, conditions, or syndromes is at least one thousand dollars (\$1,000). Also, coverage for a fixed-sum payment for a spouse or dependent may be included under the policy, provided the benefit amount included is at least twenty-five percent (25%) of the benefit amount for the certificate holder. Where coverage is advertised or otherwise represented to offer generic coverage of a specified disease, condition, or syndrome, the same dollar amounts shall be payable, regardless of the particular subtype of the disease, condition, or syndrome unless such subtype is clearly identifiable and the policy clearly differentiates that subtype and its benefits.

(14) No group 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 certificate. The items included in the outline of coverage shall appear in the sequence prescribed below:

CAUTION!

(COMPANY NAME)

(SPECIFIED DISEASE, CONDITION OR SYNDROME) COVERAGE

OUTLINE OF COVERAGE

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

(B) (Specified disease, condition or syndrome) Coverage — This certificate is designed to provide, to certificate holders, restricted coverage paying benefits ONLY when certain losses occur as a result of treatment (or diagnosis) of the specified disease, condition, or syndrome. This certificate does NOT provide general health insurance.

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

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

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

(F) A description of certificate provisions respecting continuation or conversion of coverage in the event of group policy termination.

(NEW) Sec. 38a-513-5. Drug formulary annual filing requirements

Insurers that deliver, issue for delivery, renew, amend or continue any group health insurance policy or certificate that includes prescription drug coverage and utilizes a formulary shall submit an annual report to the Commissioner regarding the development and use of formularies and P&T committees. Such report shall be in a form prescribed by the Commissioner and shall be submitted with the annual form filing.

(NEW) Sec. 38a-513-6. Minimum standards for drug formularies

No individual or group health insurance plan or certificate that offers prescription drug coverage that is subject to a formulary shall be delivered or issued for delivery in this state if the formulary does not meet the following required minimum standards:

- (1) The formulary shall be easily searchable and posted online, accessible to members and non-members.
- (2) The medications within the formulary shall be grouped in alphabetical order by therapeutic class.
- (3) Definitions or explanations, or both, of each prescription drug tier, including specialty drug tiers, shall be clearly stated.
- (4) Definitions for utilization controls, including, but not limited to, quantity or dosage controls, prior authorization, and step therapy shall be clearly stated.
- (5) Tier coverage and utilization controls for each medication (by dosage, if applicable) shall be clearly stated.
- (6) The formulary shall include information on how to obtain drugs that are off formulary.
- (7) The formulary shall specify if and how drugs may be obtained through mail order pharmacy.
- (8) The formulary shall clearly state when it was created, when it was last updated, and when the next anticipated update will be.
- (9) The formulary shall provide customer service contact information.
- (10) The formulary shall meet all additional requirements set forth by the Commissioner.

(NEW) Sec. 38a-513-7. Minimum standards for pharmaceutical and therapeutics committees

- a)(1) No insurer shall utilize a P&T committee that does not have appropriate membership.
 - (A) The majority of P&T committee members shall be practicing physicians, pharmacists, and other professionals who are licensed to prescribe drugs.
 - (B) P&T committee members shall represent a sufficient number of clinical specialties to adequately meet the needs of enrollees.
- (2) Insurers shall put in place a process to ensure that there is no conflict of interest among members of the P&T committee with respect to the issuer or any pharmaceutical manufacturer. The process shall include an explanation of how conflicts of interest are dealt with if they arise.
- (3) There shall be a process in place to ensure that P&T committee members abstain from voting if there is a conflict of interest.
 - (b) The P&T committee shall meet regularly.
 - (1) Insurers shall put in place a process, including timeframes, to ensure that the P&T committee meets and makes decisions on new FDA-approved drugs within a reasonable time frame after the drug is released into the market.
 - (2) The P&T committee shall meet at least quarterly and maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary.
 - (3) The P&T committee shall evaluate and analyze treatment protocols and procedures related to the plans' formulary at least annually.
 - (c) Insurers shall develop and document procedures to ensure appropriate formulary drug review and inclusion.
 - (1) Insurers shall provide a copy of the policies and procedures in place to ensure that the P&T committee:
 - (A) Bases clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information.
 - (B) Considers the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

- (C) Reviews new FDA-approved drugs and new FDA-approved uses for existing drugs.
- (D) Reviews policies that guide exceptions and other utilization management processes, including, but not limited to, drug utilization review, quantity limits, prior authorizations, step therapies, generic substitutions, and therapeutic interchange.
- (2) Insurers shall provide information on how often the formulary is updated on the company website and whether timeframes vary depending on whether the changes are advantageous to the enrollee.
- (3) Insurers shall develop a process to ensure the formulary recommended by the P&T committee:
 - (A) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommends drug treatment regimens that treat all disease states.
 - (B) Does not discourage enrollment of any group of enrollees through discriminatory tiering and utilization management processes.
 - (C) Includes multiple drugs, strengths and dosage forms for each therapeutic class and, if multiple drugs are available to treat a disease, they are not all placed in the highest cost share tier.
 - (D) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time and based on use of a tool set forth by the Commissioner.

(NEW) Sec. 38a-513-8. Notice to insureds regarding formulary changes

Insurers that deliver, issue for delivery, renew, amend or continue any group health insurance policy or certificate that includes prescription drug coverage and utilizes a formulary shall provide at least sixty (60) days' advance notice to each insured under the policy utilizing a prescription drug within the formulary before the insurer may remove such prescription drug from the formulary or make any change to the structure of prescription drug benefits under such policy.

(NEW) Sec. 38a-513-9. Timing for rate filings

- (a) Rate filings for health insurance plans sold to small employers shall be made no later than ninety (90) days prior to the date an insurer intends to market such plans.
- (b) For plans subject to the requirements of the PPACA, rate filings shall be filed annually no later than a date prescribed by the Commissioner. The Commissioner shall provide notice to insurers no later than thirty (30) days prior to the prescribed date each year.

(NEW) Sec. 38a-513-10. Transparency of rate filings

The information supplied to the Department to fulfill its statutory rate review requirement is not confidential. Complete rate filings including all correspondence and documentation are available through SERFF and may be posted on the Department website for review and comment by the public. All public comments shall be reviewed by the Department and considered as an additional element of the review determination.

(NEW) Sec. 38a-513-11. Rate filing process

- (a) All rate filings shall be submitted via SERFF.
- (b) For filings subject to the requirements of the PPACA, all fields in SERFF added for reporting requirements to the federal Department of Health and Human Services in accordance with PPACA shall be populated.
- (c) All rate filings shall be made in accordance with Department bulletins, notifications, and other written guidance.
- (d) Incomplete submissions may be rejected.
- (e) No rate filing shall be approved if the Department determines that it is excessive, inadequate or

unfairly discriminatory.

(f) Rates shall not be approved unless the policy forms to which they apply are approved.

(g) No rate may be marketed until the rates are approved. The Commissioner may grant conditional approval to enhance the fairness and efficiency of the marketplace.

(NEW) Sec. 38a-513-12. Minimum rate filing requirements

(a) All rate filings shall include, at a minimum, the following:

(1) A cover letter describing all policy forms affected by the requested rates or rate changes as well as the effective date of the requested rates or rate changes.

(2) The detailed development for the initial rate or rate increase.

(3) Historical experience from inception-to-date including earned premium, paid claims, incurred claims, membership, actual loss ratios and expected loss ratios.

(A) Both state-specific and nationwide experience shall be provided.

(B) Annual experience shall be provided for all years.

(4) A certification by a member of the American Academy of Actuaries that the rate filing is in compliance with this section. Such certification shall include a statement by a member of the American Academy of Actuaries that the rates are reasonable in relation to the benefits provided, and that they are not excessive, inadequate or unfairly discriminatory.

(5) Claim lag triangles.

(6) Cost for each newly mandated benefit that applies to the type of insurance for which the rate filing has been submitted.

(7) Any additional information the Commissioner deems necessary to review the rate filing.

(b) Any changes submitted after the initial rate filing shall include a version that shows the changes made as well as a clean copy to facilitate the Department's review.

(c) When the information required under subsection (a) of this section is received, actuarial review shall commence. Rate filings shall be reviewed in the order received by the Department.

(NEW) Sec. 38a-513-13. Additional rate filing requirements

(a) All rate filings for small group health insurance providing coverage of the types specified in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) shall include:

(1) A demonstration that the experience data submitted is consistent with the most recent financial statement filed by the insurer with the Department pursuant to section 38a-53a of the Connecticut General Statutes.

(2) Utilization trend by broad service category, including utilization data.

(3) Impact of cost sharing leverage on trend.

(4) Medical technology trend.

(5) Benefit buy-down analysis and impact on trend.

(6) Cost of each new benefit mandate or requirement due to a change in state or federal law, separately identified, from the experience period to the rating period.

(7) Unit cost trend by broad service category, including actual unit cost data and impact of provider contract changes from experience period to rating period (medical and prescription drug separately).

(8) An annual certification of compliance with mental health parity. Any insurer that offers a plan that includes a cost share for medical expense at a lower level than the mental health cost share shall include a demonstration that the copayment is in compliance with mental health parity.

(9) A certification and demonstration that any substitution of a non-dollar limit on an essential health benefit as permitted by the PPACA is actuarially justified.

(10) A comparison of the proposed retention charge in the filing to the most recently filed financial statement for the insurer for which this filing is being made.

(11) Monthly historical experience including earned premium, paid claims, incurred claims,

membership, actual loss ratios and expected loss ratios shall be provided for the most recent two (2) years.

(12) The current capital and surplus for the insurer for which this filing is being made.

(13) For filings subject to the PPACA, a demonstration that the rate increase requested in this filing will generate an expected medical loss ratio, for rebate purposes, that is consistent with the medical loss ratio prescribed by the federal law for individual health insurance.

(14) For filings subject to the PPACA, the Uniform Rate Review Template (URRT), the Part III Actuarial Memorandum, and the Health Insurance Oversight System rate tables. The Health Insurance Oversight System rate tables shall be filed in a portable document format. Insurers shall also provide a summary of benefits for each plan design along with the federal Department of Health and Human Services' Actuarial Value Calculator output that confirms compliance with the corresponding metal tier set forth in the PPACA. The Health Insurance Oversight System plan ID and the corresponding plan name on the summary of benefits for each plan shall be indicated.

(b) Every rate filing submission for small group health insurance providing coverage of the types specified in Connecticut General Statutes Section 38a-469 (1), (2), (4), (11) and (12) that includes an increase to previously approved rates shall include a summary of the rate increases requested and shall be clearly marked as Appendix A. The appendix shall include, but not be limited to, the following:

(1) The requested rate increase for each product contained within the rate filing and the effective date of each proposed rate increase. The requested increase for each product shall be identified as a specific percent increase or, if appropriate, a range of percent increases with an explanation of what the variance is that produces the range.

(2) Number of covered individuals for each product; number of covered policyholders; minimum current premium on a per member per month (pmpm) basis; minimum proposed premium on a pmpm basis; maximum current premium on a pmpm basis; maximum proposed premium on a pmpm basis and the percentage change.

(3) Each component of the rate increase including trend, experience adjustments and any other factors that are a component of the requested rate increase. These may be identified as a specific percent or, if appropriate, a percent range.

(4) A footnote listing any other factors that can have an impact on premium rates that have not been specifically identified in the appendix, including, but not limited to, age bands and geographic area.

(NEW) Sec. 38a-513-14. Separability

If any provision of sections 38a-513-1 to 38a-513-13, inclusive, of the Regulations of Connecticut State Agencies or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of said sections and the application of such provision to other persons or circumstances shall not be affected thereby.

Statement of Purpose:

The purpose of this regulation is to implement Section 38a-513 of the Connecticut General Statutes which provides that the Department shall adopt regulations concerning the provisions, submission, and approval of group health policies and certificates and establish policies and procedures for reviewing such policies and certificates. These regulations provide reasonable standardization and simplification of terms and coverage of group accident and sickness insurance policies and certificates in order to facilitate public understanding and comparison and to eliminate provisions contained in group accident and sickness insurance policies and certificates that may be misleading or confusing in connection either with the purchase of such coverage or with the settlement of claims and to provide for full disclosure in the sale of such coverage. These regulations will apply to all group accident and sickness insurance policies and certificates providing hospital confinement indemnity coverage or other fixed indemnity coverage, disability income protection coverage, accident only coverage, specified accident coverage, limited benefit coverage, and specified disease coverage delivered or issued for delivery in this State on and after the effective date hereof. The requirements contained in this regulation shall be in addition to any other applicable regulations or bulletins previously adopted and not inconsistent therewith. These regulations shall be effective on passage.

These regulations also include filing requirements for prescription drug formularies for group and individual health insurance policies and small group health insurance rates. Small group health insurance rates are required to be filed with the Department by statute. The standards in this regulation mirror the standards for individual rate filing. Prescription drug formularies are being used with increasing frequency in health insurance plans. These formularies are part of each health contract, and therefore, the Department should review these plan documents with all other policy form documents filed by insurers annually.