REGULATIONS OF CONNECTICUT STATE AGENCIES
INSURANCE DEPARTMENT

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Section 38a-475-1 APPLICABILITY AND SCOPE

Sections 38a-475-1 to 38a-475-6, inclusive, apply to any long-term care insurance policy or certificate form which the insurance department is requested to precertify in accordance with section 38a-475 of the general statutes.

Section 38a-475-2 DEFINITIONS

As used in sections 38a-475-1 to 38a-475-6, inclusive:

(a) "Connecticut Partnership for Long-Term Care" means the program authorized in section 17b-252 of the general statutes.

(b) "Long-Term Care Insurance Policy" means an insurance policy or certificate, the form of which has been approved by the commissioner in accordance with section 38a-481 or section 38a-513 of the general statutes, which meets the requirements of section 38a-501 or section 38a-528 of the general statutes and sections 38a-501-8 to 38a-501-24, inclusive, or sections 38a-528-1 to 38a-528-17, inclusive, of the regulations of Connecticut state agencies.

(c) "Partnership-Approved Policy" or "Precertified Long-Term Care Insurance Policy" or "Precertified Policy" means any long-term care insurance policy**,** issued for delivery to any resident of this state which is designed to provide, within the terms and conditions of the policy, contract or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of cognitive or functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for no less than one (1) year at issue after a reasonable elimination period and the form of which is precertified by the insurance department in accordance with section 38a-475 of the general statutes.

(d) "Commissioner" means the insurance commissioner.

(e) "Activities of Daily Living (ADLs)" means each of the following items: dressing, bathing, eating, toileting, continence and transferring. In each instance, an ADL deficiency is determined by reference to the need for substantial human assistance or supervision in performing that activity.

(f) "Mental Status Questionnaire (MSQ)" means the Short Portable questionnaire comprised of 10 questions for clinicians to grade a person's cognitive status.

(g) "Folstein Mini Mental State Examination" means a method for clinicians to grade a person's cognitive status.

(h) "Asset Protection" means the right extended by sections 17b-252 and 17b-253 of the general statutes to persons purchasing partnership-approved long-term care insurance policies to retain amounts

of assets equal to the sum of qualifying insurance payments made on their behalf in determining eligibility for the Medicaid program.

(i) "Authorized Agent" means a person who has been designated as agent by the insured in writing to the insurance company, or is acting for the insured under a duly executed power of attorney, or is the insured's duly appointed conservator or guardian.

(j) "Insured Event" means, for purposes of determining asset protection for a privately insured individual, that any one of the following criteria shall have been satisfied:

(1) The individual has a documented need for substantial human assistance, or supervision, with two or more of the following Activities of Daily Living (ADL's): dressing, bathing, eating, toileting, continence and transferring; or

(2) The individual has been assessed using the Mental Status Questionnaire, and has seven or more incorrect responses on the test; or

(3) The individual exhibits specific behavior problems requiring daily supervision, including but not limited to wandering, abusive or assaultive behavior, poor judgement or uncooperativeness which poses a danger to self or others, and extreme or bizarre personal hygiene habits; and has either taken the MSQ and has four or more incorrect responses, or has taken the Folstein Mini Mental State Examination and achieved a score of 23 or lower.

(4) For purposes of determining eligibility for benefits under a partnership-approved policy, the "insured event" shall use, at a minimum, the following ADLs: dressing, bathing, eating, toileting and transferring and shall be no less restrictive than the "insured event" used for purposes of determining asset protection as defined in subdivisions (1), (2), and (3) of this subsection.

(5) The provisions of this subsection shall be used for purposes of determining asset protection, except that federal regulations promulgated under the Health Insurance Portability and Accountability act of 1996 (Public Law 104-191), shall control to the extent that a provision of this subsection is in conflict with said federal regulations.

(k) "Access Agency" means an organization that provides case management services, including assessments and reassessments, care plan development, and coordination and monitoring of home and community-based services and has been approved as an access agency by the Office of Policy and Management and Department of Social Services as meeting the requirements for such agency as defined in section 17b-342 of the general statutes.

(l) "Connecticut Home Care Program for the Elderly of the Department of Social Services" means the program authorized by section 17b-342 of the general statutes.

(m) "Plan of Care" means a written individualized plan of home and community services (including but not limited to "Home and Community-Based Services") which specifies the type and frequency of all services required to maintain the individual at home or in the community, the service providers, and the cost of services, regardless of whether or not there is an actual charge for the service.

(n) "Family Member" means an individual's husband, wife, natural parent, child or sibling, adopted child or parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild.

(o) "Service Summary" means a written summary prepared by an insurer for an individual policyholder which identifies the specific partnership-approved policy, the total benefits paid for services rendered to date and the amount qualifying for asset protection.

(p) "Policyholder" means a certificate holder under a group long-term care insurance policy or a partnership-approved group long-term care insurance policy or the owner of an individual long-term care insurance policy or a partnership-approved individual long-term care insurance policy.

(q) "Home And Community-Based Services" means, at a minimum, the provision of skilled services provided in the home or community such as skilled nursing care, physical, occupational, respiratory and speech therapy; and home health aide services and support services provided in the home or community which shall include, homemaker, adult day health care and respite care services.

(r) "Uniform Data Set (UDS)" means the reporting requirements for the Connecticut Partnership for Long-Term Care defined in the document "Partnership for Long-Term Care, Long-Term Care Insurance Uniform Data Set Reporting Requirements and Documentation" issued from time to time by the Office of Policy and Management.

(s) "Plan of Action Requirements" means the set of instructions produced and updated by the Office of Policy and Management that insurance companies shall comply with in order to meet the requirements of section 38a-475-5(e) of the regulations of Connecticut state agencies.

(t) "Partnership-Approval" or "Precertification" means the process by which a long-term care policy or certificate form is precertified by the Insurance Department in accordance with section 38a-475 of the general statutes.

(u) "Before You Buy" means a publication produced, and issued from time to time, by the Office of Policy and Management which includes a complete description of the Connecticut Partnership for Long-Term Care.

Section 38a-475-3 PARTNERSHIP-APPROVAL OF LONG-TERM CARE POLICIES

No long-term care insurance policy shall be precertified as partnership-approved for purposes of the Connecticut Partnership for Long-Term Care, unless the requirements of sections 38a-475-1 to 38a-475-6, inclusive, of the regulations of Connecticut state agencies are complied with.

Section 38a-475-4 CONDITIONS FOR PARTNERSHIP-APPROVAL

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

(b) The following standards apply to partnership-approved long-term care policies as defined herein and are in addition to all other requirements of sections 38a-475-1 to 38a-475-6, inclusive, of the regulations of Connecticut state agencies.

(c) Each company seeking partnership-approval for a long-term care insurance product shall:

(1) Notify the Insurance Department in writing that it will provide to the consumer, prior to any application for a partnership-approved policy, a complete description of the Connecticut Partnership for Long-Term Care as prepared by the Office Of Policy and Management, including the Connecticut partnership's toll free phone number, and an outline of coverage.

(2) Offer the option of or include a provision for Home and Community-Based Services, with a minimum benefit of one year at issue, in addition to nursing home care.

All home care plans shall include case management services delivered by an access agency. Case management services shall include, but need not be limited to, the development of a comprehensive individualized assessment and plan of care and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

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

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

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

(4) At a minimum, issue a policy which provides a nursing home benefit of at least $107.00 a day if issued in 1998. For each year after 1998, the minimum daily nursing home benefit shall be 5% greater than the previous year's minimum, rounded up to the nearest dollar amount. No policy shall pay for care in excess of the actual charges.

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

Policies that pay benefits based on a percentage of costs, and not a daily benefit amount, shall provide benefits which are equal to at least 70% of the actual charges incurred by the insured or at least 70% of the average private pay rate provided by the Department of Social Services for each service.

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

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

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

_____ _____

Signature of Applicant(s) Date

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

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

_____ _____

(Signature of Applicant(s)) Date

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

NOTICE TO APPLICANT REGARDING
MANDATORY INFLATION PROTECTION

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

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

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

(7) Issue a policy which shall include a provision which allows for a thirty (30) day period within which coverage may be cancelled by the applicant by delivering or mailing the evidence of coverage to the insurer or the agent through whom it was effected for a full refund of any premium that was paid. The policy shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate to the insurer or its agent for cancellation within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured is not satisfied for any reason.

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

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

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

programs designed to meet the requirements of this subdivision shall receive prior approval from the Office of Policy and Management.

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

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

(B) The original policy was issued with the equivalent of one year of coverage.

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

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

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

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

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

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

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

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

(e) Long-term care insurance policies in force at the effective date of this regulation may be amended to qualify for partnership-approval by fulfilling all partnership-approval requirements.

Section 38a-475-5 INSURER DOCUMENTATION AND REPORTING

Unless otherwise noted, the requirements of subsections (a) to (f), inclusive, of this section refer to insurer documentation and reporting requirements for partnership-approved policies.

(a) Each insurer in fulfilling its reporting requirements shall adhere to the most recent specifications set forth in the Partnership For Long-Term Care Long-Term Care Insurance Uniform Data Set (UDS) and Connecticut state-specific requirements as noted in the Connecticut Partnership for Long-Term Care section of the state specific appendices of the UDS documentation. All reports are due to the Office of Policy and Management no later than thirty (30) days after the close of the reporting periods specified for the respective reports.

(b) **Maintaining Auditing Information**. Each insurer shall maintain information as stipulated in subdivisions (1), (2) and (3) of this subsection, on all policyholders who have ever received any benefit under the policy. Such information shall be updated at least quarterly; but this requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's condition which is not otherwise required by federal or state statute or regulation. When a policyholder who has received any benefit dies or lapses his policy for any other reason the insurer shall retain the stipulated information for at least five years after the time when the policy ceases to be in force. At the time the policy ceases to be in force, the insurer shall notify the policyholder of their right to request their service records as stipulated in subdivisions (1), (2) and (3) of this subsection. The insurer shall also, upon request, provide such policyholder and the policyholder's authorized agent, if any, with a complete copy of the insurer's service records as stipulated in subdivisions (1), (2) and (3) of this subsection. These records shall be provided to the policyholder and policyholder's authorized agent, if any, within sixty days of the request. The insurer shall enclose with the records a statement advising the former policyholder that it is in his or her interests to retain the records if he or she may ever wish to establish eligibility for Medicaid.

The information includes:

(1) Evidence that the Insured Event has taken place. The occurrence of the Insured Event may be documented in any of the following ways:

(A) By access agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(B) By an assessment conducted by the Connecticut Home Care Program for the Elderly of the Department of Social Services;

(C) By an assessment of a resident of a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) as required by section 1919 (b)(3) of the Social Security Act;

(D) By an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in subparagraphs (a), (b) and (c) of this subdivision. Assessments described in this subparagraph are valid only for persons for whom evidence was not available or not provided in a manner described in subparagraphs (a), (b) or (c) of this subdivision. These assessments shall be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment shall sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

(2) Description of services provided under the policy:

(A) Name, address, phone number and license number (if applicable) of provider(s);

(B) Amount, date and nature of services provided indicating under which category, if any, the service qualifies for asset protection;

(C) Dollar amounts paid by the insurers, whether on an indemnity, expense incurred, or other basis;

(D) The charges of the service providers, including copies of invoices for all services counting towards asset protection;

(E) Identification of the access agency (if applicable) and copies of all assessments and reassessments.

(3) In order for home and community-based services to qualify for asset protection, they shall be in accord with a plan of care approved by an access agency. If the policyholder has received any benefits delivered as part of a plan of care, the insurer shall retain the following:

(A) A copy of the original plan of care;

(B) Copies of any reviews of the plan of care;

(C) Copies of any changes made in the plan of care. The plan of care shall document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count towards asset protection after the access agency adds the documented need for and description of the new services to the plan of care. In cases when the service begins before the revisions to the plan of care are made, the new services will only count towards asset protection if the revisions to the plan of care are made within ten business days of the commencement of the new services. Insurers shall maintain initial assessments and subsequent reassessments as part of insured event documentation.

(c) **Reporting on Asset Protection**. Each insurer shall send an asset protection report at least quarterly to each policyholder who has received any benefits since the last asset protection report sent to the policyholder. Each asset protection report shall include the following information:

(1) The amount of asset protection for which the policyholder had qualified prior to the quarter covered by the report.

(2) The total benefits paid by the insurer for services rendered during the quarter.

(3) A statement of the amount of benefits paid by the insurer for services rendered during the quarter which qualify for asset protection.

(4) A summary total of the amount paid to date under the policy which qualifies for asset protection.

(A) The format and wording for the asset protection report shall be described in the Plan of Action Requirements provided by the Office of Policy and Management.

(B) Copies of all asset protection reports shall also be sent to the Office of Policy and Management on a quarterly basis.

(C) Asset protection reports shall be subject to audit by the Department of Social Services under the same requirements as specified in subsection (e)(2) of this section which covers the records in subsection (b) of this section.

(d) **Preparing A Service Summary**. Each insurer shall prepare a service summary at the client's request specifically for the purpose of the policyholder applying for Medicaid. Also the insurer shall prepare a service summary when the policyholder has exhausted his/her benefits under the policy or when the policy ceases to be in force for a reason other than the death of the policyholder, whichever occurs first. The service summary shall identify the specific partnership-approved policy, the total benefits paid for services rendered to date, and the amount qualifying for asset protection. This Service Summary is separate and in addition to the information requirement described above in subsection (b) of this section. The format and wording for the service summary report shall be described in the Plan of Action Requirements provided by the Office of Policy and Management. Copies of all service summary reports shall also be sent to the Office of Policy and Management on a quarterly basis.

(e) **Submitting Plan of Action**. Each insurer shall, prior to partnership-approval by the commissioner, submit to the Office of Policy and Management, and the Department of Social Services a plan for complying with the information maintenance and documentation requirements set forth in this section. No policy shall be partnership-approved until the Office of Policy and Management and the Department of Social Services have approved the insurer's documentation plan for the policy. When each of the two agencies determine that a plan of action is adequate, they shall advise the Commissioner and the insurer of that fact in writing. If they determine that there are shortcomings in a plan of action, they shall advise the Commissioner and the insurer of those shortcomings in writing and shall cooperate with the insurer in efforts to resolve them. The documentation plan shall include, but need not be limited to, the following:

(1) The location where records will be kept. Records required for purposes of the Connecticut Partnership for Long-Term Care shall be available at one location, which is easily available to staff of the Department of Social Services and the Insurance Department.

(2) The insurer shall agree to give the Department of Social Services access to all information, described in subsection (b) of this section, Maintaining Auditing Information, on an aggregate basis for all policyholders and on an individual basis for all policyholders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for Department of Social Services to determine if an insurer's system for documenting asset protection is functioning correctly. Department of Social Services shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes. The insurer shall be responsible for any reasonable expenses associated with any audit of its Connecticut Partnership for Long-Term Care records or systems that occurs outside of the state of Connecticut.

(3) The name, job title, address and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with the Office of Policy and Management, and the Department of Social Services, concerning the information.

(4) Methods for determining when insurance benefits qualify for asset protection, including documentation of the insured event, description of services, documentation of charges and benefits paid, and documentation of plans of care when required.

(5) Description of manual and electronic systems which will be used in maintaining the required information.

(6) Information which will be retained which is needed to comply with these regulations.

(7) Forms and descriptions of standard procedures for maintaining and reporting the information required. In the event that all or part of the data will be provided in computer-readable form, the specific medium (i.e., tape, diskette, etc.) shall be specified in addition to a description of the relevant file(s).

(8) The asset protection statement to be used in the policy, certificate when used, and outline of coverage. Format for the asset protection statement is included in the Plan of Action Requirements.

(9) A participation agreement with the Office of Policy and Management to be signed by an officer of the insurer. The participation agreement is included in the Plan of Action Requirements provided by the Office of Policy and Management. The participation agreement shall include, but need not be limited to:

(A) A statement that the insurer agrees to make a good faith effort to make revisions and upgrades to their partnership-approved policies and certificates by no later than the time they make revisions and upgrades to their policies and certificates available in Connecticut that are not partnership-approved; and

(B) A statement that the insurer will provide to the Office of Policy and Management a toll-free phone number that the public can utilize to obtain information regarding the insurer's partnership-approved policies and certificates. Such toll-free phone number shall be staffed with personnel familiar with the insurer's partnership-approved policies and certificates.

(10) Forms filed with the Commissioner for partnership-approval, including, but not limited to, policy forms, outlines of coverage, applications, riders, and endorsements.

(f) **Auditing and Correcting Deficiencies In Insurer Record-Keeping**. The following represent instances of insurer deficiency, procedures for resolution, asset protection determinations and required penalties:

(1) Within one year of the first time that any policyholder of a particular company's policy has met the criteria for the insured event, and as often as Department of Social Services deems necessary thereafter, Department of Social Services shall conduct a systems audit of that company's records. The insurer shall be responsible for advising Department of Social Services when this one year period has begun. Department of Social Services shall promptly inform each insurer of inaccuracies and other potential problems discovered in its systems audits, and shall cooperate with insurers in efforts to correct any problems in the insurer's methods of operation. It is the responsibility of the insurer to make any necessary corrections.

(2) Department of Social Services shall periodically audit a sample of individual applications to Medicaid of persons who have qualified for asset protection. Department of Social Services shall have the final decision concerning sample sizes and other auditing methods. Department of Social Services shall promptly advise insurers of any problems discovered, and shall cooperate with insurers in efforts to correct any problems in the insurer's methods of operation. Department of Social Services shall also notify the insurer of any obligations described in this subsection to hold clients harmless.

(3) The Commissioner of Social Services may enter into voluntary arrangements with insurers of partnership-approved long-term care insurance policies under which the Commissioner of Social Services, or his designee, would issue binding determinations as to whether or not services qualify for asset protection. Policyholders may submit requests for information and advice through their insurer or access agency. When the procedures described in this subdivision are followed in all material respects, the written determinations of the Commissioner of Social Services or his designee concerning whether services qualify for asset protection shall be binding upon the Department of Social Services in all subsequent actions, and the Department of Social Services shall not make any assertion contradicting these determinations in any action arising in this subsection:

(A) All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the Commissioner of Social Services or his designee in writing. These requests may include but are not limited to requests for determinations in the following areas:

(i) Whether the insured event has occurred and has been adequately documented;

(ii) Whether a plan of care is required;

(iii) Whether a revision of a plan of care is required;

(iv) Whether a service or services is in accord with the Plan of Care;

(v) Whether a service is of such a nature as to qualify for asset protection as defined in Department of Social Services' Uniform Policy Manual;

(vi) Whether the applicable amount is the amount paid by the insurer or the amount charged for the service;

(vii) Whether a provider or proposed provider of service(s) is a "family member" as defined in Department of Social Services' Uniform Policy Manual.

(B) The Commissioner of Social Services or his designee may require insurers and access agencies submitting requests for determinations to provide all records and other information necessary for making a determination. These may include, but not necessarily be limited to, assessments, plans of care, and invoices for services rendered. The party providing the records and other information shall be

responsible for their accuracy. If any records or other information are later determined to be materially inaccurate, the determination based on the inaccurate information shall not be binding on Department of Social Services in subsequent actions. In the case of a policyholder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of this subsection will apply in the same manner as for any other policyholder.

(C) The Commissioner of Social Services or his designee shall render a determination on each request in writing. Each determination of the Commissioner of Social Services or his designee shall state the reason(s) for the determination, including the relevant facts, documentation of facts, statutes, regulations, and policies.

(D) A copy of all determinations of the Commissioner of Social Services or his designee shall be kept on file at Department of Social Services, together with the related records and information. The original of the determination shall be sent to the insurer or the access agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or policyholder's authorized agent.

(4) When an audit or other review by the Department of Social Services reveals deficiencies in the record keeping procedures of an insurer, Department of Social Services shall notify the insurer of the deficiencies, and establish a reasonable deadline for correction. If an insurer fails to correct deficiencies within a reasonable period of time, the Department of Social Services shall notify the Commissioner of the deficiencies.

(5) The Commissioner reserves the right to remove partnership-approval status of a long-term care insurance policy on account of an insurer's failure to comply with any of the provisions of sections 38a-475-1 to 38a-475-6, inclusive, of the regulations of Connecticut state agencies. If the Commissioner removes partnership-approval status from a long-term care insurance policy, policyholders who purchased their policies while the policy was partnership-approved will retain their right to asset protection. Policyholders who purchase their policies after the removal of partnership-approval status will have no right to asset protection.

When a policy's partnership-approval status is removed, or an insurer discontinues selling a partnership-approved policy, the insurer shall continue to comply with the documentation and reporting requirements in this section regarding policies already issued. In the event an insurer enters into an assumption agreement covering partnership-approved policies, the insurer shall obtain an undertaking from the assuming insurer that it will continue to comply with the documentation and reporting requirements applicable to the assumed policies.

(6) If an insurer prepares a Service Summary or Asset Protection Report which is used in a Medicaid application for a policyholder, and the client is found eligible for Medicaid, and the policyholder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the insurer's Service Summary, Asset Protection Report or documentation of services, the Department of Social Services may require the insurer to pay for services counting towards asset protection required by the policyholder until the insurer has paid an amount equal to the amount of the insurer's errors; after which the policyholder, if otherwise eligible, shall qualify for Medicaid coverage.

(7) If the Department of Social Services determines that an insurer's records pertaining to a policyholder who has received Medicaid benefits are in such condition that the Department of Social Services cannot determine whether the policyholder qualifies for asset protection, the Department of Social Services may require the insurer to pay for services counting towards asset protection required

by the policyholder until the insurer has paid an amount equal to the amount of the insurers errors; after which the policyholder, if otherwise eligible, shall qualify for Medicaid coverage.

Compliance with subparagraphs (6) and (7) above, is a requirement for a policy to retain partnership-approval.

Section 38a-475-6 SEPARABILITY

If any provision of sections 38a-475-1 to 38a-475-6, inclusive, or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations and the application of such provision to other persons or circumstances shall not be affected thereby.