General Assembly

Raised Bill No. 329

February Session, 2020

LCO No. 2026

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING LONG-TERM CARE INSURANCE POLICIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-1 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2021*):

3 Terms used in this title and section 2 of this act, unless it appears from
4 the context to the contrary, shall have a scope and meaning as set forth
5 in this section.

6 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly
7 through one or more intermediaries, controls, is controlled by or is
8 under common control with another person.

9 (2) "Alien insurer" means any insurer that has been chartered by or
10 organized or constituted within or under the laws of any jurisdiction or
11 country without the United States.

12 (3) "Annuities" means all agreements to make periodical payments
13 where the making or continuance of all or some of the series of the
14 payments, or the amount of the payment, is dependent upon the

15 continuance of human life or is for a specified term of years. This
16 definition does not apply to payments made under a policy of life
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

19 (5) "Control", "controlled by" or "under common control with" means
20 the possession, direct or indirect, of the power to direct or cause the
21 direction of the management and policies of a person, whether through
22 the ownership of voting securities, by contract other than a commercial
23 contract for goods or nonmanagement services, or otherwise, unless the
24 power is the result of an official position with the person.

25 (6) "Domestic insurer" means any insurer that has been chartered by,
26 incorporated, organized or constituted within or under the laws of this
27 state.

28 (7) "Domestic surplus lines insurer" means any domestic insurer that
29 has been authorized by the commissioner to write surplus lines
30 insurance.

31 (8) "Foreign country" means any jurisdiction not in any state, district
32 or territory of the United States.

33 (9) "Foreign insurer" means any insurer that has been chartered by or
34 organized or constituted within or under the laws of another state or a
35 territory of the United States.

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
37 unable to pay its obligations when they are due, or when its admitted
38 assets do not exceed its liabilities plus the greater of: (A) Capital and
39 surplus required by law for its organization and continued operation;
40 or (B) the total par or stated value of its authorized and issued capital
41 stock. For purposes of this subdivision "liabilities" shall include but not
42 be limited to reserves required by statute or by regulations adopted by
43 the commissioner in accordance with the provisions of chapter 54 or
44 specific requirements imposed by the commissioner upon a subject

45 company at the time of admission or subsequent thereto.

46 (11) "Insurance" means any agreement to pay a sum of money,
47 provide services or any other thing of value on the happening of a
48 particular event or contingency or to provide indemnity for loss in
49 respect to a specified subject by specified perils in return for a
50 consideration. In any contract of insurance, an insured shall have an
51 interest which is subject to a risk of loss through destruction or
52 impairment of that interest, which risk is assumed by the insurer and
53 such assumption shall be part of a general scheme to distribute losses
54 among a large group of persons bearing similar risks in return for a
55 ratable contribution or other consideration.

56 (12) "Insurer" or "insurance company" includes any person or
57 combination of persons doing any kind or form of insurance business
58 other than a fraternal benefit society, and shall include a receiver of any
59 insurer when the context reasonably permits.

60 (13) "Insured" means a person to whom or for whose benefit an
61 insurer makes a promise in an insurance policy. The term includes
62 policyholders, subscribers, members and beneficiaries. This definition
63 applies only to the provisions of this title and does not define the
64 meaning of this word as used in insurance policies or certificates.

65 (14) "Life insurance" means insurance on human lives and insurances
66 pertaining to or connected with human life. The business of life
67 insurance includes granting endowment benefits, granting additional
68 benefits in the event of death by accident or accidental means, granting
69 additional benefits in the event of the total and permanent disability of
70 the insured, and providing optional methods of settlement of proceeds.
71 Life insurance includes burial contracts to the extent provided by
72 section 38a-464.

73 (15) "Mutual insurer" means any insurer without capital stock, the
74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a

76 limited liability company, an association, a joint stock company, a
77 business trust, an unincorporated organization or other legal entity.

78 (17) "Policy" means any document, including attached endorsements
79 and riders, purporting to be an enforceable contract, which
80 memorializes in writing some or all of the terms of an insurance
81 contract.

82 (18) "State" means any state, district, or territory of the United States.

83 (19) "Subsidiary" of a specified person means an affiliate controlled
84 by the person directly, or indirectly through one or more intermediaries.

85 (20) "Unauthorized insurer" or "nonadmitted insurer" means an
86 insurer that has not been granted a certificate of authority by the
87 commissioner to transact the business of insurance in this state or an
88 insurer transacting business not authorized by a valid certificate.

89 (21) "United States" means the United States of America, its territories
90 and possessions, the Commonwealth of Puerto Rico and the District of
91 Columbia.

92 Sec. 2. (NEW) (*Effective January 1, 2021*) (a) For the purposes of this
93 section, "long-term care policy" has the same meaning as provided in
94 section 38a-501 of the general statutes, as amended by this act, or section
95 38a-528 of the general statutes, as amended by this act, as applicable.

96 (b) The commissioner shall, after consulting with other state
97 governments and conducting a nation-wide review, develop and
98 prescribe a minimum set of affordable benefit options to be offered by
99 an insurance company, fraternal benefit society, hospital service
100 corporation, medical service corporation or health care center that files
101 a rate filing under section 38a-501 of the general statutes, as amended
102 by this act, or section 38a-528 of the general statutes, as amended by this
103 act, for an increase in premium rates for a long-term care policy that is
104 for twenty per cent or more. The commissioner shall send to each
105 insurance company, fraternal benefit society, hospital service

106 corporation, medical service corporation or health care center that files
107 such a rate filing a notice disclosing such minimum set of affordable
108 benefit options.

109 (c) The commissioner may adopt regulations, in accordance with the
110 provisions of chapter 54 of the general statutes, to carry out the purposes
111 of this section.

112 Sec. 3. Section 38a-501 of the general statutes is repealed and the
113 following is substituted in lieu thereof (*Effective January 1, 2021*):

114 (a) (1) As used in this section <u>and section 2 of this act</u>, "long-term care
115 policy" means any individual health insurance policy delivered or
116 issued for delivery to any resident of this state on or after July 1, 1986,
117 that is designed to provide, within the terms and conditions of the
118 policy, benefits on an expense-incurred, indemnity or prepaid basis for
119 necessary care or treatment of an injury, illness or loss of functional
120 capacity provided by a certified or licensed health care provider in a
121 setting other than an acute care hospital, for at least one year after an
122 elimination period (A) not to exceed one hundred days of confinement,
123 or (B) of over one hundred days but not to exceed two years of
124 confinement, provided such period is covered by an irrevocable trust in
125 an amount estimated to be sufficient to furnish coverage to the grantor
126 of the trust for the duration of the elimination period. Such trust shall
127 create an unconditional duty to pay the full amount held in trust
128 exclusively to cover the costs of confinement during the elimination
129 period, subject only to taxes and any trustee's charges allowed by law.
130 Payment shall be made directly to the provider. The duty of the trustee
131 may be enforced by the state, the grantor or any person acting on behalf
132 of the grantor. A long-term care policy shall provide benefits for
133 confinement in a nursing home or confinement in the insured's own
134 home or both. Any additional benefits provided shall be related to long-
135 term treatment of an injury, illness or loss of functional capacity. "Long-
136 term care policy" does not include any such policy that is offered
137 primarily to provide basic Medicare supplement coverage, basic
138 medical-surgical expense coverage, hospital confinement indemnity

139 coverage, major medical expense coverage, disability income protection
140 coverage, accident only coverage, specified accident coverage or limited
141 benefit health coverage.

142 (2) (A) Notwithstanding any provision of the general statutes, no
143 insurance company, fraternal benefit society, hospital service
144 corporation, medical service corporation or health care center may
145 deliver, issue for delivery, renew, continue or amend any long-term care
146 policy in this state on or after January 1, 2021, unless the insurance
147 company, fraternal benefit society, hospital service corporation, medical
148 service corporation or health care center is authorized or licensed to sell
149 long-term care insurance and at least one other line of insurance in this
150 state.

151 (B) No insurance company, fraternal benefit society, hospital service
152 corporation, medical service corporation or health care center
153 delivering, issuing for delivery, renewing, continuing or amending any
154 long-term care policy in this state may refuse to accept, or refuse to make
155 reimbursement pursuant to, a claim for benefits submitted by or
156 prepared with the assistance of a managed residential community, as
157 defined in section 19a-693, in accordance with subdivision (7) of
158 subsection (a) of section 19a-694, solely because such claim for benefits
159 was submitted by or prepared with the assistance of a managed
160 residential community.

161 **[**(B)**]** (C) Each insurance company, fraternal benefit society, hospital
162 service corporation, medical service corporation or health care center
163 delivering, issuing for delivery, renewing, continuing or amending any
164 long-term care policy in this state shall, upon receipt of a written
165 authorization executed by the insured, (i) disclose information to a
166 managed residential community for the purpose of determining such
167 insured's eligibility for an insurance benefit or payment, and (ii) provide
168 a copy of the initial acceptance or declination of a claim for benefits to
169 the managed residential community at the same time such acceptance
170 or declination is made to the insured.

171 (b) (1) No insurance company, fraternal benefit society, hospital
172 service corporation, medical service corporation or health care center
173 may deliver or issue for delivery any long-term care policy that has a
174 loss ratio of less than sixty per cent for any individual long-term care
175 policy. An issuer shall not use or change premium rates for a long-term
176 care policy unless the rates have been filed with and approved by the
177 **[**Insurance Commissioner**]** commissioner. Any rate filings or rate
178 revisions shall demonstrate that anticipated claims in relation to
179 premiums when combined with actual experience to date can be
180 expected to comply with the loss ratio requirement of this section. A rate
181 filing shall include the factors and methodology used to estimate
182 irrevocable trust values if the policy includes an option for the
183 elimination period specified in subdivision (1) of subsection (a) of this
184 section. If the commissioner determines, in the commissioner's
185 discretion, that an insurance company, fraternal benefit society, hospital
186 service corporation, medical service corporation or health care center
187 deliberately or recklessly included a misstatement of fact in, or
188 deliberately or recklessly omitted a statement of fact from, a rate filing
189 filed on or after January 1, 2021, that caused a long-term care policy to
190 be underpriced by at least fifty per cent, the commissioner shall refer
191 such rate filing to the Attorney General for an investigation pursuant to
192 section 5 of this act.

193 (2) (A) Any insurance company, fraternal benefit society, hospital
194 service corporation, medical service corporation or health care center
195 that files a rate filing for an increase in premium rates for a long-term
196 care policy that is for twenty per cent or more shall spread the increase
197 over a period of not less than three years. Such company, society,
198 corporation or center shall use a periodic rate increase that is actuarially
199 equivalent to a single rate increase and a current interest rate for the
200 period chosen.

201 (B) Prior to implementing a premium rate increase, each such
202 company, society, corporation or center shall:

203 (i) Notify its policyholders of such premium rate increase and make

204 available to such policyholders the additional choice of reducing the
205 policy benefits to reduce the premium rate or electing coverage that
206 reflects the minimum set of affordable benefit options developed by the
207 commissioner pursuant to section 2 of this act. Such notice shall include
208 a description of such policy benefit reductions and minimum set of
209 affordable benefit options. The premium rates for any benefit reductions
210 shall be based on the new premium rate schedule;

211 (ii) Provide policyholders not less than thirty calendar days to elect a
212 reduction in policy benefits or coverage that reflects the minimum set of
213 affordable benefit options developed by the commissioner pursuant to
214 section 2 of this act; and

215 (iii) Include a statement in such notice that if a policyholder fails to
216 elect a reduction in policy benefits or coverage that reflects the
217 minimum set of affordable benefit options developed by the
218 commissioner pursuant to section 2 of this act by the end of the notice
219 period and has not cancelled the policy, the policyholder will be deemed
220 to have elected to retain the existing policy benefits.

221 (c) (1) No such company, society, corporation or center may deliver
222 or issue for delivery any long-term care policy without providing, at the
223 time of solicitation or application for purchase or sale of such coverage,
224 full and fair written disclosure of the benefits and limitations of the
225 policy.

226 (2) (A) The applicant shall sign an acknowledgment at the time of
227 application for such policy that the company, society, corporation or
228 center has provided the written disclosure required under this
229 subsection to the applicant. If the method of application does not allow
230 for such signature at the time of application, the applicant shall sign
231 such acknowledgment not later than at the time of delivery of such
232 policy.

233 (B) Except for a long-term care policy for which no applicable
234 premium rate revision or rate schedule increases can be made or as
235 otherwise provided in subdivision (3) of this subsection, such disclosure

236 shall include:

237 (i) A statement that the policy may be subject to rate increases in the
238 future;

239 (ii) An explanation of potential future premium rate revisions and the
240 policyholder's option in the event of a premium rate revision;

241 (iii) The premium rate or rate schedule applicable to the applicant
242 that will be in effect until such company, society, corporation or center
243 files a request with the **[**Insurance Commissioner**]** <u>commissioner</u> for a
244 revision to such premium rate or rate schedule;

245 (iv) An explanation of how a premium rate or rate schedule revision
246 will be applied that includes a description of when such rate or rate
247 schedule revision will be effective; and

248 (v) Information regarding each premium rate increase, if any, over
249 the past ten years on such policy form or similar policy forms for this
250 state or any other state, that identifies, at a minimum, (I) the policy forms
251 for which premium rates have been increased, (II) the calendar years
252 when each such policy form was available for purchase, and (III) the
253 amount or percentage of each increase. The percentage may be
254 expressed as a percentage of the premium rate prior to the increase or
255 as minimum and maximum percentages if the rate increase is variable
256 by rating characteristics.

257 (C) The company, society, corporation or center may provide, in a fair
258 manner, any additional explanatory information related to a premium
259 rate or rate schedule revision.

260 (3) (A) Any such company, society, corporation or center may
261 exclude from the disclosure required under subparagraph (B) of
262 subdivision (2) of this subsection premium rate increases that only
263 apply to blocks of business or long-term care policies acquired from a
264 nonaffiliated company, society, corporation or center and that occurred
265 prior to the acquisition.

266 (B) If an acquiring company, society, corporation or center files a
267 request for a premium rate increase on or before January 1, 2015, or the
268 end of a twenty-four-month period after the acquisition, whichever is
269 later, for a block of policy forms or long-term care policies acquired from
270 a nonaffiliated company, society, corporation or center, such acquiring
271 company, society, corporation or center may exclude from the
272 disclosure required under subparagraph (B) of subdivision (2) of this
273 subsection such premium rate increase, except that the nonaffiliated
274 company, society, corporation or center selling such block of policy
275 forms or long-term care policies shall include such premium rate
276 increase in such disclosure.

277 (C) If an acquiring company, society, corporation or center under
278 subparagraph (B) of this subdivision files a subsequent request, even
279 within the twenty-four-month period specified in said subparagraph,
280 for a premium rate increase on the same block of policy forms or long-
281 term care policies set forth in said subparagraph, the acquiring
282 company, society, corporation or center shall include in the disclosure
283 required under subparagraph (B) of subdivision (2) of this subsection
284 such premium rate increase and any premium rate increase filed and
285 approved pursuant to subparagraph (B) of this subdivision.

286 (4) If the offering for any long-term care policy includes an option for
287 the elimination period specified in subdivision (1) of subsection (a) of
288 this section, the application form for such policy and the face page of
289 such policy shall contain a clear and conspicuous disclosure that the
290 irrevocable trust may not be sufficient to cover all costs during the
291 elimination period.

292 (d) No such company, society, corporation or center may deliver or
293 issue for delivery any long-term care policy on or after July 1, 2008,
294 without offering, at the time of solicitation or application for purchase
295 or sale of such coverage, an option to purchase a policy that includes a
296 nonforfeiture benefit. Such offer of a nonforfeiture benefit may be in the
297 form of a rider attached to such policy. In the event the nonforfeiture
298 benefit is declined, such company, society, corporation or center shall

299 provide a contingent benefit upon lapse that shall be available for a
300 specified period of time following a substantial increase in premium
301 rates. Not later than July 1, 2008, the [Insurance Commissioner]
302 commissioner shall adopt regulations, in accordance with chapter 54, to
303 implement the provisions of this subsection. Such regulations shall
304 specify the type of nonforfeiture benefit that may be offered, the
305 standards for such benefit, the period of time during which a contingent
306 benefit upon lapse will be available and the substantial increase in
307 premium rates that trigger a contingent benefit upon lapse in
308 accordance with the Long-Term Care Insurance Model Regulation
309 adopted by the National Association of Insurance Commissioners.

310 (e) The [Insurance Commissioner] commissioner shall adopt
311 regulations, in accordance with chapter 54, that address (1) the insured's
312 right to information prior to the insured replacing an accident and
313 sickness policy with a long-term care policy, (2) the insured's right to
314 return a long-term care policy to the insurer, within a specified period
315 of time after delivery, for cancellation, and (3) the insured's right to
316 accept by the insured's signature, and prior to it becoming effective, any
317 rider or endorsement added to a long-term care policy after the issuance
318 date of such policy. The [Insurance Commissioner] commissioner shall
319 adopt such additional regulations as the commissioner deems necessary
320 in accordance with chapter 54 to carry out the purpose of this section.

321 (f) The [Insurance Commissioner] commissioner may, upon written
322 request by any such company, society, corporation or center, issue an
323 order to modify or suspend a specific provision of this section or any
324 regulation adopted pursuant thereto with respect to a specific long-term
325 care policy upon a written finding that: (1) The modification or
326 suspension would be in the best interest of the insureds; (2) the purposes
327 to be achieved could not be effectively or efficiently achieved without
328 such modification or suspension; and (3) (A) the modification or
329 suspension is necessary to the development of an innovative and
330 reasonable approach for insuring long-term care, (B) the policy is to be
331 issued to residents of a life care or continuing care retirement
332 community or other residential community for the elderly and the

333 modification or suspension is reasonably related to the special needs or
334 nature of such community, or (C) the modification or suspension is
335 necessary to permit long-term care policies to be sold as part of, or in
336 conjunction with, another insurance product. Whenever the
337 commissioner decides not to issue such an order, the commissioner shall
338 provide written notice of such decision to the requesting party in a
339 timely manner.

340 (g) Upon written request by any such company, society, corporation
341 or center, the **[**Insurance Commissioner**]** <u>commissioner</u> may issue an
342 order to extend the preexisting condition exclusion period, as
343 established by regulations adopted pursuant to this section, for
344 purposes of specific age group categories in a specific long-term care
345 policy form whenever the commissioner makes a written finding that
346 such an extension is in the best interest to the public. Whenever the
347 commissioner decides not to issue such an order, the commissioner shall
348 provide written notice of such decision to the requesting party in a
349 timely manner.

350 (h) The provisions of section 38a-19 shall be applicable to any such
351 requesting party aggrieved by any order or decision of the
352 commissioner made pursuant to subsections (f) and (g) of this section.

353 Sec. 4. Section 38a-528 of the general statutes is repealed and the
354 following is substituted in lieu thereof (*Effective January 1, 2021*):

355 (a) (1) As used in this section <u>and section 2 of this act</u>, "long-term care
356 policy" means any group health insurance policy or certificate delivered
357 or issued for delivery to any resident of this state on or after July 1, 1986,
358 that is designed to provide, within the terms and conditions of the policy
359 or certificate, benefits on an expense-incurred, indemnity or prepaid
360 basis for necessary care or treatment of an injury, illness or loss of
361 functional capacity provided by a certified or licensed health care
362 provider in a setting other than an acute care hospital, for at least one
363 year after a reasonable elimination period. A long-term care policy shall
364 provide benefits for confinement in a nursing home or confinement in

365 the insured's own home or both. Any additional benefits provided shall
366 be related to long-term treatment of an injury, illness or loss of
367 functional capacity. "Long-term care policy" does not include any such
368 policy or certificate that is offered primarily to provide basic Medicare
369 supplement coverage, basic medical-surgical expense coverage, hospital
370 confinement indemnity coverage, major medical expense coverage,
371 disability income protection coverage, accident only coverage, specified
372 accident coverage or limited benefit health coverage.

373 (2) (A) Notwithstanding any provision of the general statutes, no
374 insurance company, fraternal benefit society, hospital service
375 corporation, medical service corporation or health care center may
376 deliver, issue for delivery, renew, continue or amend any long-term care
377 policy in this state on or after January 1, 2021, unless the insurance
378 company, fraternal benefit society, hospital service corporation, medical
379 service corporation or health care center is authorized or licensed to sell
380 long-term care insurance and at least one other line of insurance in this
381 state.

382 (B) No insurance company, fraternal benefit society, hospital service
383 corporation, medical service corporation or health care center
384 delivering, issuing for delivery, renewing, continuing or amending any
385 long-term care policy in this state may refuse to accept, or refuse to make
386 reimbursement pursuant to, a claim for benefits submitted by or
387 prepared with the assistance of a managed residential community, as
388 defined in section 19a-693, in accordance with subdivision (7) of
389 subsection (a) of section 19a-694, solely because such claim for benefits
390 was submitted by or prepared with the assistance of a managed
391 residential community.

392 **[**(B)**]** (C) Each insurance company, fraternal benefit society, hospital
393 service corporation, medical service corporation or health care center
394 delivering, issuing for delivery, renewing, continuing or amending any
395 long-term care policy in this state shall, upon receipt of a written
396 authorization executed by the insured, (i) disclose information to a
397 managed residential community for the purpose of determining such

398 insured's eligibility for an insurance benefit or payment, and (ii) provide
399 a copy of the initial acceptance or declination of a claim for benefits to
400 the managed residential community at the same time such acceptance
401 or declination is made to the insured.

402 (b) (1) No insurance company, fraternal benefit society, hospital
403 service corporation, medical service corporation or health care center
404 may deliver or issue for delivery any long-term care policy or certificate
405 that has a loss ratio of less than sixty-five per cent for any group long-
406 term care policy. An issuer shall not use or change premium rates for a
407 long-term care policy or certificate unless the rates have been filed with
408 the **[**Insurance Commissioner**]** commissioner. Deviations in rates to
409 reflect policyholder experience shall be permitted, provided each policy
410 form shall meet the loss ratio requirement of this section. Any rate filings
411 or rate revisions shall demonstrate that anticipated claims in relation to
412 premiums when combined with actual experience to date can be
413 expected to comply with the loss ratio requirement of this section. On
414 an annual basis, an insurer shall submit to the **[**Insurance
415 Commissioner**]** commissioner an actuarial certification of the insurer's
416 continuing compliance with the loss ratio requirement of this section.
417 Any rate or rate revision may be disapproved if the commissioner
418 determines that the loss ratio requirement will not be met over the
419 lifetime of the policy form using reasonable assumptions. If the
420 commissioner determines, in the commissioner's discretion, that an
421 insurance company, fraternal benefit society, hospital service
422 corporation, medical service corporation or health care center
423 deliberately or recklessly included a misstatement of fact in, or
424 deliberately or recklessly omitted a statement of fact from, a rate filing
425 filed on or after January 1, 2021, that caused a long-term care policy to
426 be underpriced by at least fifty per cent, the commissioner shall refer
427 such rate filing to the Attorney General for an investigation pursuant to
428 section 5 of this act.

429 (2) (A) Any insurance company, fraternal benefit society, hospital
430 service corporation, medical service corporation or health care center
431 that files a rate filing for an increase in premium rates for a long-term

432 care policy that is for twenty per cent or more shall spread the increase
433 over a period of not less than three years. Such company, society,
434 corporation or center shall use a periodic rate increase that is actuarially
435 equivalent to a single rate increase and a current interest rate for the
436 period chosen.

437 (B) Prior to implementing a premium rate increase, each such
438 company, society, corporation or center shall:

439 (i) Notify its certificate holders of such premium rate increase and
440 make available to such certificate holders the additional choice of
441 reducing the policy benefits to reduce the premium rate <u>or electing</u>
442 <u>coverage that reflects the minimum set of affordable benefit options</u>
443 <u>developed by the commissioner pursuant to section 2 of this act</u>. Such
444 notice shall include a description of such policy benefit reductions <u>and</u>
445 <u>minimum set of affordable benefit options</u>. The premium rates for any
446 benefit reductions shall be based on the new premium rate schedule;

447 (ii) Provide certificate holders not less than thirty calendar days to
448 elect a reduction in policy benefits <u>or coverage that reflects the</u>
449 <u>minimum set of affordable benefit options developed by the</u>
450 <u>commissioner pursuant to section 2 of this act</u>; and

451 (iii) Include a statement in such notice that if a certificate holder fails
452 to elect a reduction in policy benefits <u>or coverage that reflects the</u>
453 <u>minimum set of affordable benefit options developed by the</u>
454 <u>commissioner pursuant to section 2 of this act</u> by the end of the notice
455 period and has not cancelled the policy, the certificate holder will be
456 deemed to have elected to retain the existing policy benefits.

457 (c) (1) No such company, society, corporation or center may deliver
458 or issue for delivery any long-term care policy without providing, at the
459 time of solicitation or application for purchase or sale of such coverage,
460 full and fair written disclosure of the benefits and limitations of the
461 policy. The provisions of this subsection shall not be applicable to
462 noncontributory plans.

463 (2) (A) The applicant shall sign an acknowledgment at the time of
464 application for such policy that the company, society, corporation or
465 center has provided the written disclosure required under this
466 subsection to the applicant. If the method of application does not allow
467 for such signature at the time of application, the applicant shall sign
468 such acknowledgment not later than at the time of delivery of such
469 policy.

470 (B) The policyholder shall provide a copy of such disclosure to each
471 eligible individual.

472 (3) (A) Except for a long-term care policy for which no applicable
473 premium rate revision or rate schedule increases can be made or as
474 otherwise provided in subdivision (4) of this subsection, such disclosure
475 shall include:

476 (i) A statement that the policy may be subject to rate increases in the
477 future;

478 (ii) An explanation of potential future premium rate revisions and the
479 policyholder's or certificate holder's option in the event of a premium
480 rate revision;

481 (iii) The premium rate or rate schedule applicable to the applicant
482 that will be in effect until such company, society, corporation or center
483 files a request with the **[**Insurance Commissioner**]** <u>commissioner</u> for a
484 revision to such premium rate or rate schedule;

485 (iv) An explanation of how a premium rate or rate schedule revision
486 will be applied that includes a description of when such rate or rate
487 schedule revision will be effective; and

488 (v) Information regarding each premium rate increase, if any, over
489 the past ten years on such policy form or similar policy forms for this
490 state or any other state, that identifies, at a minimum, (I) the policy forms
491 for which premium rates have been increased, (II) the calendar years
492 when each such policy form was available for purchase, and (III) the

493 amount or percentage of each increase. The percentage may be
494 expressed as a percentage of the premium rate prior to the increase or
495 as minimum and maximum percentages if the rate increase is variable
496 by rating characteristics.

497 (B) The company, society, corporation or center may provide, in a fair
498 manner, any additional explanatory information related to a premium
499 rate or rate schedule revision.

500 (4) (A) Any such company, society, corporation or center may
501 exclude from the disclosure required under subdivision (3) of this
502 subsection premium rate increases that only apply to blocks of business
503 or long-term care policies acquired from a nonaffiliated company,
504 society, corporation or center and that occurred prior to the acquisition.

505 (B) If an acquiring company, society, corporation or center files a
506 request for a premium rate increase on or before January 1, 2015, or the
507 end of a twenty-four-month period after the acquisition, whichever is
508 later, for a block of policy forms or long-term care policies acquired from
509 a nonaffiliated company, society, corporation or center such acquiring
510 company, society, corporation or center may exclude from the
511 disclosure required under subdivision (3) of this subsection such
512 premium rate increase, except that the nonaffiliated company, society,
513 corporation or center selling such block of policy forms or long-term
514 care policies shall include such premium rate increase in such
515 disclosure.

516 (C) If an acquiring company, society, corporation or center under
517 subparagraph (B) of this subdivision files a subsequent request, even
518 within the twenty-four-month period specified in said subparagraph,
519 for a premium rate increase on the same block of policy forms or long-
520 term care policies set forth in said subparagraph, the acquiring
521 company, society, corporation or center shall include in the disclosure
522 required under subdivision (3) of this subsection such premium rate
523 increase and any premium rate increase filed and approved pursuant to
524 subparagraph (B) of this subdivision.

525 (d) The [Insurance Commissioner] commissioner shall adopt
526 regulations, in accordance with chapter 54, that address (1) the insured's
527 right to information prior to his replacing an accident and sickness
528 policy with a long-term care policy, (2) the insured's right to return a
529 long-term care policy to the insurer, within a specified period of time
530 after delivery, for cancellation, and (3) the insured's right to accept by
531 the insured's signature, and prior to it becoming effective, any rider or
532 endorsement added to a long-term care policy after the issuance date of
533 such policy, provided (A) any regulations adopted pursuant to
534 subdivisions (1) and (2) of this subsection shall not be applicable to (i)
535 any long-term care policy that is delivered or issued for delivery to one
536 or more employers or labor organizations, or to a trust or to the trustees
537 of a fund established by one or more employers or labor organizations,
538 or a combination thereof or for members or former members or a
539 combination thereof, of the labor organizations, or (ii) noncontributory
540 plans, and (B) any regulations adopted pursuant to subdivision (3) of
541 this subsection shall not be applicable to any group long-term care
542 policy. The [Insurance Commissioner] commissioner shall adopt such
543 additional regulations as the commissioner deems necessary in
544 accordance with said chapter 54 to carry out the purpose of this section.

545 (e) The [Insurance Commissioner] commissioner may, upon written
546 request by any such company, society, corporation or center, issue an
547 order to modify or suspend a specific provision of this section or any
548 regulation adopted pursuant thereto with respect to a specific long-term
549 care policy upon a written finding that: (1) The modification or
550 suspension would be in the best interest of the insureds; (2) the purposes
551 to be achieved could not be effectively or efficiently achieved without
552 such modification or suspension; and (3) (A) the modification or
553 suspension is necessary to the development of an innovative and
554 reasonable approach for insuring long-term care, (B) the policy is to be
555 issued to residents of a life care or continuing care retirement
556 community or other residential community for the elderly and the
557 modification or suspension is reasonably related to the special needs or
558 nature of such community, or (C) the modification or suspension is

559 necessary to permit long-term care policies to be sold as part of, or in
560 conjunction with, another insurance product. Whenever the
561 commissioner decides not to issue such an order, the commissioner shall
562 provide written notice of such decision to the requesting party in a
563 timely manner.

564 (f) Upon written request by any such company, society, corporation
565 or center, the **[**Insurance Commissioner**]** <u>commissioner</u> may issue an
566 order to extend the preexisting condition exclusion period, as
567 established by regulations adopted pursuant to this section, for
568 purposes of specific age group categories in a specific long-term care
569 policy form whenever he makes a written finding that such an extension
570 is in the best interest to the public. Whenever the commissioner decides
571 not to issue such an order, the commissioner shall provide written notice
572 of such decision to the requesting party in a timely manner.

573 (g) The provisions of section 38a-19 shall be applicable to any such
574 requesting party aggrieved by any order or decision of the
575 commissioner made pursuant to subsections (e) and (f) of this section.

576 Sec. 5. (NEW) (*Effective January 1, 2021*) The Attorney General is
577 authorized to investigate and, in consultation with the Insurance
578 Commissioner, take such action as is deemed necessary to protect, and
579 secure compensation for, an insured under a long-term care policy that
580 is the subject of a rate filing that the Insurance Commissioner refers to
581 the Attorney General pursuant to subdivision (1) of subsection (b) of
582 section 38a-501 of the general statutes, as amended by this act, or
583 subdivision (1) of subsection (b) of section 38a-528 of the general
584 statutes, as amended by this act. Such action may include, but need not
585 be limited to, bringing a civil action to recover damages reflecting
586 excessive executive compensation, shareholder contributions and
587 broker fees paid by the insurance company, fraternal benefit society,
588 hospital service corporation, medical service corporation or health care
589 center that filed such rate filing and distributing such damages to the
590 insured. For the purposes of this section, "long-term care policy" has the
591 same meaning as provided in section 38a-501 of the general statutes, as

592 amended by this act, or section 38a-528 of the general statutes, as
593 amended by this act, as applicable.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2021*	38a-1
Sec. 2	*January 1, 2021*	New section
Sec. 3	*January 1, 2021*	38a-501
Sec. 4	*January 1, 2021*	38a-528
Sec. 5	*January 1, 2021*	New section

Statement of Purpose:

To: (1) Require the Insurance Commissioner to develop and disseminate a minimum set of affordable benefit options for individual and group long-term care policies; (2) provide that no insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may exclusively deliver, issue, renew, continue or amend such policies in this state; (3) require the Insurance Commissioner to refer an insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center that files a rate filing for a long-term care policy that contains a deliberate or reckless misstatement or omission of fact to the Attorney General for investigation; (4) require each such insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center to disclose to insureds the minimum set of affordable benefit options developed by the Insurance Commissioner; and (5) authorize the Attorney General to investigate a rate filing referred to the Attorney General by the Insurance Commissioner and take action to protect and secure compensation for the insured under the long-term care policy that is the subject of such rate filing.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]