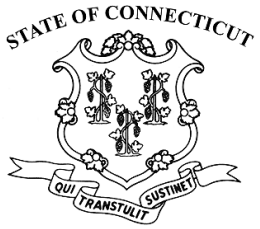


***Substitute House Bill No. 5521***

# *Public Act No. 16-63*

## *AN ACT CONCERNING SHORT-TERM CARE INSURANCE.*

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

Section 1. Section 38a-469 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in this title, unless the context otherwise requires or a different meaning is specifically prescribed, "health insurance" policy means insurance providing benefits due to illness or injury, resulting in loss of life, loss of earnings, or expenses incurred, and includes the following types of coverage: (1) Basic hospital expense coverage; (2) basic medical-surgical expense coverage; (3) hospital confinement indemnity coverage; (4) major medical expense coverage; (5) disability income protection coverage; (6) accident only coverage; (7) **[**long term**]** long-term care coverage; (8) specified accident coverage; (9) Medicare supplement coverage; (10) limited benefit health coverage; (11) hospital or medical service plan contract; (12) hospital and medical coverage provided to subscribers of a health care center; (13) specified disease coverage; (14) TriCare supplement coverage; (15) travel health coverage; **[**and**]** (16) single service ancillary health coverage, including, but not limited to, dental, vision or prescription drug coverage; and (17) short-term care coverage.

Sec. 2. (NEW) (*Effective October 1, 2016*) (a) As used in this section, "short-term care policy" means any individual health insurance policy delivered or issued for delivery to any resident of this state that is designed to provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for a period not exceeding three hundred days. "Short-term care policy" does not include any such policy that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(b) (1) No short-term care policy shall be delivered or issued for delivery to any resident in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the Insurance Commissioner. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if the form does not conform to the requirements of law, or if the form contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 of the general statutes shall apply to such orders.

(2) No rate filed under the provisions of subdivision (1) of this subsection shall be effective until it has been approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate if it fails to comply with such standards.

(c) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any short-term care policy without providing, at the time of solicitation or application for purchase or sale of such coverage, full and fair written disclosure of the benefits and limitations of the policy.

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

(3) Except for a short-term care policy for which no applicable premium rate revision or rate schedule increases can be made, such disclosure shall include:

(A) A statement in not less than twelve-point bold face type that the policy does not provide long-term care insurance coverage and is not a long-term care insurance policy or a Connecticut Partnership for Long-Term Care insurance policy;

(B) A statement that the policy may be subject to rate increases in

the future;

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

(D) The premium rate or rate schedule applicable to the applicant that will be in effect until such company, society, corporation or center files a request with the commissioner for a revision to such premium rate or rate schedule.

(d) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any short-term care policy in this state may refuse to accept, or refuse to make reimbursement pursuant to, a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693 of the general statutes, in accordance with subdivision (7) of subsection (a) of section 19a-694 of the general statutes, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(2) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any short-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (A) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (B) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the

provisions of this section. Such regulations shall include, but need not be limited to, (1) the permissible loss ratio for a short-term care policy, if any, (2) the permissible exclusionary periods for coverage under a short-term care policy, if any, (3) the circumstances under which a short-term care policy will be renewable, and (4) the benefits payable under a short-term care policy in relation to other insurance coverage that provides benefits to the insured.

Approved May 31, 2016