



General Assembly

January Session, 2021

**Raised Bill No. 1046**

LCO No. 4598



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

***AN ACT CONCERNING LONG-TERM CARE INSURANCE.***

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 Section 38a-1 of the general statutes is repealed and the  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, 2022*):

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, 2022*) (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, 2022*):

114 (a) (1) As used in this section and section 2 of this act, "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, 2022, 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 [(2) (A)] (B) No insurance company, fraternal benefit society, hospital  
152 service 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, 2022, 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 and not file a rate filing for an  
198 increase in premium rates for the long-term care policy during the  
199 period chosen. Such company, society, corporation or center shall use a  
200 periodic rate increase that is actuarially equivalent to a single rate  
201 increase and a current interest rate for the period chosen.

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

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

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

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

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

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

234 (B) Except for a long-term care policy for which no applicable  
235 premium rate revision or rate schedule increases can be made or as



236 otherwise provided in subdivision (3) of this subsection, such disclosure  
237 shall include:

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

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

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

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

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

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

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

266 prior to the acquisition.

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

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

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

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

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

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

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

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

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

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

354 Sec. 4. Section 38a-528 of the general statutes is repealed and the  
355 following is substituted in lieu thereof (*Effective January 1, 2022*):

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

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

374 (2) (A) Notwithstanding any provision of the general statutes, no  
375 insurance company, fraternal benefit society, hospital service  
376 corporation, medical service corporation or health care center may  
377 deliver, issue for delivery, renew, continue or amend any long-term care  
378 policy in this state on or after January 1, 2022, unless the insurance  
379 company, fraternal benefit society, hospital service corporation, medical  
380 service corporation or health care center is authorized or licensed to sell  
381 long-term care insurance and at least one other line of insurance in this  
382 state.

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

393 [(B)] (C) Each insurance company, fraternal benefit society, hospital  
394 service corporation, medical service corporation or health care center  
395 delivering, issuing for delivery, renewing, continuing or amending any  
396 long-term care policy in this state shall, upon receipt of a written

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

403 (b) (1) No insurance company, fraternal benefit society, hospital  
404 service corporation, medical service corporation or health care center  
405 may deliver or issue for delivery any long-term care policy or certificate  
406 that has a loss ratio of less than sixty-five per cent for any group long-  
407 term care policy. An issuer shall not use or change premium rates for a  
408 long-term care policy or certificate unless the rates have been filed with  
409 the [Insurance Commissioner] commissioner. Deviations in rates to  
410 reflect policyholder experience shall be permitted, provided each policy  
411 form shall meet the loss ratio requirement of this section. Any rate filings  
412 or rate revisions shall demonstrate that anticipated claims in relation to  
413 premiums when combined with actual experience to date can be  
414 expected to comply with the loss ratio requirement of this section. On  
415 an annual basis, an insurer shall submit to the [Insurance  
416 Commissioner] commissioner an actuarial certification of the insurer's  
417 continuing compliance with the loss ratio requirement of this section.  
418 Any rate or rate revision may be disapproved if the commissioner  
419 determines that the loss ratio requirement will not be met over the  
420 lifetime of the policy form using reasonable assumptions. If the  
421 commissioner determines, in the commissioner's discretion, that an  
422 insurance company, fraternal benefit society, hospital service  
423 corporation, medical service corporation or health care center  
424 deliberately or recklessly included a misstatement of fact in, or  
425 deliberately or recklessly omitted a statement of fact from, a rate filing  
426 filed on or after January 1, 2022, that caused a long-term care policy to  
427 be underpriced by at least fifty per cent, the commissioner shall refer  
428 such rate filing to the Attorney General for an investigation pursuant to  
429 section 5 of this act.

430 (2) (A) Any insurance company, fraternal benefit society, hospital

431 service corporation, medical service corporation or health care center  
432 that files a rate filing for an increase in premium rates for a long-term  
433 care policy that is for twenty per cent or more shall spread the increase  
434 over a period of not less than three years and not file a rate filing for an  
435 increase in premium rates for the long-term care policy during the  
436 period chosen. Such company, society, corporation or center shall use a  
437 periodic rate increase that is actuarially equivalent to a single rate  
438 increase and a current interest rate for the period chosen.

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

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

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

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

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

463 policy. The provisions of this subsection shall not be applicable to  
464 noncontributory plans.

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

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

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

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

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

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

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

490 (v) Information regarding each premium rate increase, if any, over  
491 the past ten years on such policy form or similar policy forms for this  
492 state or any other state, that identifies, at a minimum, (I) the policy forms



493 for which premium rates have been increased, (II) the calendar years  
494 when each such policy form was available for purchase, and (III) the  
495 amount or percentage of each increase. The percentage may be  
496 expressed as a percentage of the premium rate prior to the increase or  
497 as minimum and maximum percentages if the rate increase is variable  
498 by rating characteristics.

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

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

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

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

525 increase and any premium rate increase filed and approved pursuant to  
526 subparagraph (B) of this subdivision.

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

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

559 modification or suspension is reasonably related to the special needs or  
560 nature of such community, or (C) the modification or suspension is  
561 necessary to permit long-term care policies to be sold as part of, or in  
562 conjunction with, another insurance product. Whenever the  
563 commissioner decides not to issue such an order, the commissioner shall  
564 provide written notice of such decision to the requesting party in a  
565 timely manner.

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

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

578 Sec. 5. (NEW) (*Effective January 1, 2022*) The Attorney General is  
579 authorized to investigate and, in consultation with the Insurance  
580 Commissioner, take such action as is deemed necessary to protect, and  
581 secure compensation for, an insured under a long-term care policy that  
582 is the subject of a rate filing that the Insurance Commissioner refers to  
583 the Attorney General pursuant to subdivision (1) of subsection (b) of  
584 section 38a-501 of the general statutes, as amended by this act, or  
585 subdivision (1) of subsection (b) of section 38a-528 of the general  
586 statutes, as amended by this act. Such action may include, but need not  
587 be limited to, bringing a civil action to recover damages reflecting  
588 excessive executive compensation, shareholder contributions and  
589 broker fees paid by the insurance company, fraternal benefit society,  
590 hospital service corporation, medical service corporation or health care  
591 center that filed such rate filing and distributing such damages to the

592 insured. For the purposes of this section, "long-term care policy" has the  
 593 same meaning as provided in section 38a-501 of the general statutes, as  
 594 amended by this act, or section 38a-528 of the general statutes, as  
 595 amended by this act, as applicable.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2022</i>	38a-1
Sec. 2	<i>January 1, 2022</i>	New section
Sec. 3	<i>January 1, 2022</i>	38a-501
Sec. 4	<i>January 1, 2022</i>	38a-528
Sec. 5	<i>January 1, 2022</i>	New section

**Statement of Purpose:**

To: (1) Require the Insurance Commissioner to develop and disseminate a minimum set of affordable benefit options for long-term care policies; (2) provide that an insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center shall not deliver, issue, renew, continue or amend a long-term care policy in this state unless such company, society, corporation or center is authorized or licensed to sell long-term care insurance and at least one other line of insurance 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) provide that 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 seeks an increase of twenty per cent or more and spreads such increase over a period of not less than three years shall not file a rate filing for an increase in premium rates for the long-term care policy during said period; (5) require 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 to disclose to insureds the minimum set of affordable benefit options developed by the Insurance Commissioner; and (6) 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.]*