



General Assembly

Amendment

January Session, 2021

LCO No. 9950



Offered by:

- REP. WOOD, 29th Dist.
- REP. PAVALOCK-D'AMATO, 77th Dist.
- REP. COMEY, 102nd Dist.
- REP. NUCCIO, 53rd Dist.
- REP. MESKERS, 150th Dist.

To: Senate Bill No. 1046

File No. 371

Cal. No. 544

(As Amended by Senate Amendment Schedule "A")

"AN ACT CONCERNING LONG-TERM CARE INSURANCE."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

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 Section 38a-1 of the general statutes is repealed and the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

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

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

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

14 (3) "Annuities" means all agreements to make periodical payments
15 where the making or continuance of all or some of the series of the
16 payments, or the amount of the payment, is dependent upon the
17 continuance of human life or is for a specified term of years. This
18 definition does not apply to payments made under a policy of life
19 insurance.

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

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

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

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

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

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

38 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
39 unable to pay its obligations when they are due, or when its admitted
40 assets do not exceed its liabilities plus the greater of: (A) Capital and

41 surplus required by law for its organization and continued operation;
42 or (B) the total par or stated value of its authorized and issued capital
43 stock. For purposes of this subdivision "liabilities" shall include but not
44 be limited to reserves required by statute or by regulations adopted by
45 the commissioner in accordance with the provisions of chapter 54 or
46 specific requirements imposed by the commissioner upon a subject
47 company at the time of admission or subsequent thereto.

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

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

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

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

73 Life insurance includes burial contracts to the extent provided by
74 section 38a-464.

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

77 (16) "Person" means an individual, a corporation, a partnership, a
78 limited liability company, an association, a joint stock company, a
79 business trust, an unincorporated organization or other legal entity.

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

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

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

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

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

94 Sec. 2. (NEW) (*Effective January 1, 2022*) (a) For the purposes of this
95 section, "long-term care policy" has the same meaning as provided in
96 section 38a-501 of the general statutes, as amended by this act, or section
97 38a-528 of the general statutes, as amended by this act, as applicable.

98 (b) The commissioner shall, after consulting with other state
99 governments and conducting a nation-wide review, develop and
100 prescribe a minimum set of affordable benefit options to be offered by
101 an insurance company, fraternal benefit society, hospital service

102 corporation, medical service corporation or health care center that files
103 a rate filing under section 38a-501 of the general statutes, as amended
104 by this act, or section 38a-528 of the general statutes, as amended by this
105 act, for an increase in premium rates for a long-term care policy that is
106 for twenty per cent or more. The commissioner shall send to each
107 insurance company, fraternal benefit society, hospital service
108 corporation, medical service corporation or health care center that files
109 such a rate filing a notice disclosing such minimum set of affordable
110 benefit options.

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

114 Sec. 3. Section 38a-501 of the general statutes is repealed and the
115 following is substituted in lieu thereof (*Effective January 1, 2022*):

116 (a) (1) As used in this section and section 2 of this act, "long-term care
117 policy" means any individual health insurance policy delivered or
118 issued for delivery to any resident of this state on or after July 1, 1986,
119 that is designed to provide, within the terms and conditions of the
120 policy, benefits on an expense-incurred, indemnity or prepaid basis for
121 necessary care or treatment of an injury, illness or loss of functional
122 capacity provided by a certified or licensed health care provider in a
123 setting other than an acute care hospital, for at least one year after an
124 elimination period (A) not to exceed one hundred days of confinement
125 or longer if mutually agreed by the insurance company, fraternal benefit
126 society, hospital service corporation, medical service corporation or
127 health care center and the policyholder, or (B) of over one hundred days
128 but not to exceed two years of confinement, provided such period is
129 covered by an irrevocable trust in an amount estimated to be sufficient
130 to furnish coverage to the grantor of the trust for the duration of [the]
131 such elimination period. Such trust shall create an unconditional duty
132 to pay the full amount held in trust exclusively to cover the costs of
133 confinement during [the] such elimination period, subject only to taxes
134 and any trustee's charges allowed by law. Payment shall be made

135 directly to the provider. The duty of the trustee may be enforced by the
136 state, the grantor or any person acting on behalf of the grantor. A long-
137 term care policy shall provide benefits for confinement in a nursing
138 home or confinement in the insured's own home or both. Any additional
139 benefits provided shall be related to long-term treatment of an injury,
140 illness or loss of functional capacity. "Long-term care policy" does not
141 include any such policy that is offered primarily to provide basic
142 Medicare supplement coverage, basic medical-surgical expense
143 coverage, hospital confinement indemnity coverage, major medical
144 expense coverage, disability income protection coverage, accident only
145 coverage, specified accident coverage or limited benefit health coverage.

146 (2) (A) Notwithstanding any provision of the general statutes, no
147 insurance company, fraternal benefit society, hospital service
148 corporation, medical service corporation or health care center may
149 deliver, issue for delivery, renew, continue or amend any long-term care
150 policy in this state on or after January 1, 2022, unless the insurance
151 company, fraternal benefit society, hospital service corporation, medical
152 service corporation or health care center is authorized or licensed to sell
153 long-term care insurance and at least one other line of insurance in this
154 state.

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

165 [(B)] (C) Each insurance company, fraternal benefit society, hospital
166 service corporation, medical service corporation or health care center
167 delivering, issuing for delivery, renewing, continuing or amending any

168 long-term care policy in this state shall, upon receipt of a written
169 authorization executed by the insured, (i) disclose information to a
170 managed residential community for the purpose of determining such
171 insured's eligibility for an insurance benefit or payment, and (ii) provide
172 a copy of the initial acceptance or declination of a claim for benefits to
173 the managed residential community at the same time such acceptance
174 or declination is made to the insured.

175 (b) (1) No insurance company, fraternal benefit society, hospital
176 service corporation, medical service corporation or health care center
177 may deliver or issue for delivery any long-term care policy that has a
178 loss ratio of less than sixty per cent for any individual long-term care
179 policy. An issuer shall not use or change premium rates for a long-term
180 care policy unless the rates have been filed with and approved by the
181 [Insurance Commissioner] commissioner. Any rate filings or rate
182 revisions shall demonstrate that anticipated claims in relation to
183 premiums when combined with actual experience to date can be
184 expected to comply with the loss ratio requirement of this section. A rate
185 filing shall include the factors and methodology used to estimate
186 irrevocable trust values if the policy includes an option for the
187 elimination period specified in subparagraph (B) of subdivision (1) of
188 subsection (a) of this section.

189 (2) (A) Any insurance company, fraternal benefit society, hospital
190 service corporation, medical service corporation or health care center
191 that files a rate filing for an increase in premium rates for a long-term
192 care policy [that] shall send a notice to its policyholders, not later than
193 the date on which such company, society, corporation or center files
194 such rate filing and in at least twelve-point font, disclosing that such
195 company, society, corporation or center has filed such rate filing and the
196 manner in which its policyholders may participate in the premium rate
197 approval process. If an insurance company, fraternal benefit society,
198 hospital service corporation, medical service corporation or health care
199 center files a rate filing for an increase in premium rates for a long-term
200 care policy that is for twenty per cent or more, such company, society,
201 corporation or center shall spread the increase over a period of not less

202 than three years and not file a rate filing for an increase in premium rates
203 for the long-term care policy during the period chosen. Such company,
204 society, corporation or center shall use a periodic rate increase that is
205 actuarially equivalent to a single rate increase and a current interest rate
206 for the period chosen.

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

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

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

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

227 (c) (1) No such company, society, corporation or center may deliver
228 or issue for delivery any long-term care policy without providing, at the
229 time of solicitation or application for purchase or sale of such coverage;
230 []

231 (A) A full and fair written disclosure of the benefits and limitations
232 of the policy; and

233 (B) A consultation with an insurance producer licensed in this state
234 concerning:

235 (i) The benefits and limitations of the policy;

236 (ii) Unless the policy is a policy for which no premium rate revision
237 or rate schedule increases can be made, the possibility that the policy
238 may be subject to rate increases in the future; and

239 (iii) The potential costs and benefits to the applicant of an elimination
240 period that exceeds one hundred days of confinement and whether such
241 an elimination period is appropriate for the applicant.

242 (2) (A) The applicant shall sign an acknowledgment at the time of
243 application for such policy that the company, society, corporation or
244 center has provided to the applicant the written disclosure required
245 under this subsection [to the applicant] and the consultation with an
246 insurance producer licensed in this state required under subparagraph
247 (B) of subdivision (1) of this subsection. If the method of application
248 does not allow for such signature at the time of application, the
249 applicant shall sign such acknowledgment not later than at the time of
250 delivery of such policy.

251 (B) Except for a long-term care policy for which no applicable
252 premium rate revision or rate schedule increases can be made or as
253 otherwise provided in subdivision (3) of this subsection, such disclosure
254 shall include:

255 (i) A statement that the policy may be subject to rate increases in the
256 future and a projection of future rates for at least the next ten years;

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

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

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

266 (v) Information regarding each premium rate increase, if any, over
267 the past ten years on such policy form [or] and not more than two similar
268 policy forms for this state or any other state, that identifies, at a
269 minimum, (I) the policy forms for which premium rates have been
270 increased, (II) the calendar years when each such policy form was
271 available for purchase, and (III) the amount or percentage of each
272 increase. The percentage may be expressed as a percentage of the
273 premium rate prior to the increase or as minimum and maximum
274 percentages if the rate increase is variable by rating characteristics.

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

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

284 (B) If an acquiring company, society, corporation or center files a
285 request for a premium rate increase on or before January 1, 2015, or the
286 end of a twenty-four-month period after the acquisition, whichever is
287 later, for a block of policy forms or long-term care policies acquired from
288 a nonaffiliated company, society, corporation or center, such acquiring
289 company, society, corporation or center may exclude from the
290 disclosure required under subparagraph (B) of subdivision (2) of this
291 subsection such premium rate increase, except that the nonaffiliated
292 company, society, corporation or center selling such block of policy
293 forms or long-term care policies shall include such premium rate
294 increase in such disclosure.

295 (C) If an acquiring company, society, corporation or center under
296 subparagraph (B) of this subdivision files a subsequent request, even
297 within the twenty-four-month period specified in said subparagraph,
298 for a premium rate increase on the same block of policy forms or long-
299 term care policies set forth in said subparagraph, the acquiring
300 company, society, corporation or center shall include in the disclosure
301 required under subparagraph (B) of subdivision (2) of this subsection
302 such premium rate increase and any premium rate increase filed and
303 approved pursuant to subparagraph (B) of this subdivision.

304 (4) If the offering for any long-term care policy includes an option for
305 the elimination period specified in subparagraph (B) of subdivision (1)
306 of subsection (a) of this section, the application form for such policy and
307 the face page of such policy shall contain a clear and conspicuous
308 disclosure that the irrevocable trust may not be sufficient to cover all
309 costs during [the] such elimination period.

310 (d) No such company, society, corporation or center may deliver or
311 issue for delivery any long-term care policy on or after July 1, 2008,
312 without offering, at the time of solicitation or application for purchase
313 or sale of such coverage, an option to purchase a policy that includes a
314 nonforfeiture benefit. Such offer of a nonforfeiture benefit may be in the
315 form of a rider attached to such policy. In the event the nonforfeiture
316 benefit is declined, such company, society, corporation or center shall
317 provide a contingent benefit upon lapse that shall be available for a
318 specified period of time following a substantial increase in premium
319 rates. Not later than July 1, 2008, the [Insurance Commissioner]
320 commissioner shall adopt regulations, in accordance with chapter 54, to
321 implement the provisions of this subsection. Such regulations shall
322 specify the type of nonforfeiture benefit that may be offered, the
323 standards for such benefit, the period of time during which a contingent
324 benefit upon lapse will be available and the substantial increase in
325 premium rates that trigger a contingent benefit upon lapse in
326 accordance with the Long-Term Care Insurance Model Regulation
327 adopted by the National Association of Insurance Commissioners.

328 (e) The [Insurance Commissioner] commissioner shall adopt
329 regulations, in accordance with chapter 54, that address (1) the insured's
330 right to information prior to the insured replacing an accident and
331 sickness policy with a long-term care policy, (2) the insured's right to
332 return a long-term care policy to the insurer, within a specified period
333 of time after delivery, for cancellation, and (3) the insured's right to
334 accept by the insured's signature, and prior to it becoming effective, any
335 rider or endorsement added to a long-term care policy after the issuance
336 date of such policy. The [Insurance Commissioner] commissioner shall
337 adopt such additional regulations as the commissioner deems necessary
338 in accordance with chapter 54 to carry out the purpose of this section.

339 (f) The [Insurance Commissioner] commissioner may, upon written
340 request by any such company, society, corporation or center, issue an
341 order to modify or suspend a specific provision of this section or any
342 regulation adopted pursuant thereto with respect to a specific long-term
343 care policy upon a written finding that: (1) The modification or
344 suspension would be in the best interest of the insureds; (2) the purposes
345 to be achieved could not be effectively or efficiently achieved without
346 such modification or suspension; and (3) (A) the modification or
347 suspension is necessary to the development of an innovative and
348 reasonable approach for insuring long-term care, (B) the policy is to be
349 issued to residents of a life care or continuing care retirement
350 community or other residential community for the elderly and the
351 modification or suspension is reasonably related to the special needs or
352 nature of such community, or (C) the modification or suspension is
353 necessary to permit long-term care policies to be sold as part of, or in
354 conjunction with, another insurance product. Whenever the
355 commissioner decides not to issue such an order, the commissioner shall
356 provide written notice of such decision to the requesting party in a
357 timely manner.

358 (g) Upon written request by any such company, society, corporation
359 or center, the [Insurance Commissioner] commissioner may issue an
360 order to extend the preexisting condition exclusion period, as
361 established by regulations adopted pursuant to this section, for

362 purposes of specific age group categories in a specific long-term care
363 policy form whenever the commissioner makes a written finding that
364 such an extension is in the best interest to the public. Whenever the
365 commissioner decides not to issue such an order, the commissioner shall
366 provide written notice of such decision to the requesting party in a
367 timely manner.

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

371 (i) Notwithstanding any provision of the general statutes, the
372 commissioner shall, at least annually, examine the books and records of
373 each insurance company, fraternal benefit society, hospital service
374 corporation, medical service corporation or health care center
375 delivering, issuing for delivery, renewing, continuing or amending any
376 long-term care policy in this state to ensure the solvency of such
377 company, society, corporation or center.

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

380 (a) (1) As used in this section and section 2 of this act, "long-term care
381 policy" means any group health insurance policy or certificate delivered
382 or issued for delivery to any resident of this state on or after July 1, 1986,
383 that is designed to provide, within the terms and conditions of the policy
384 or certificate, benefits on an expense-incurred, indemnity or prepaid
385 basis for necessary care or treatment of an injury, illness or loss of
386 functional capacity provided by a certified or licensed health care
387 provider in a setting other than an acute care hospital, for at least one
388 year after a reasonable elimination period. A long-term care policy shall
389 provide benefits for confinement in a nursing home or confinement in
390 the insured's own home or both. Any additional benefits provided shall
391 be related to long-term treatment of an injury, illness or loss of
392 functional capacity. "Long-term care policy" does not include any such
393 policy or certificate that is offered primarily to provide basic Medicare

394 supplement coverage, basic medical-surgical expense coverage, hospital
395 confinement indemnity coverage, major medical expense coverage,
396 disability income protection coverage, accident only coverage, specified
397 accident coverage or limited benefit health coverage.

398 (2) (A) Notwithstanding any provision of the general statutes, no
399 insurance company, fraternal benefit society, hospital service
400 corporation, medical service corporation or health care center may
401 deliver, issue for delivery, renew, continue or amend any long-term care
402 policy in this state on or after January 1, 2022, unless the insurance
403 company, fraternal benefit society, hospital service corporation, medical
404 service corporation or health care center is authorized or licensed to sell
405 long-term care insurance and at least one other line of insurance in this
406 state.

407 [(2) (A)] (B) No insurance company, fraternal benefit society, hospital
408 service corporation, medical service corporation or health care center
409 delivering, issuing for delivery, renewing, continuing or amending any
410 long-term care policy in this state may refuse to accept, or refuse to make
411 reimbursement pursuant to, a claim for benefits submitted by or
412 prepared with the assistance of a managed residential community, as
413 defined in section 19a-693, in accordance with subdivision (7) of
414 subsection (a) of section 19a-694, solely because such claim for benefits
415 was submitted by or prepared with the assistance of a managed
416 residential community.

417 [(B)] (C) Each insurance company, fraternal benefit society, hospital
418 service corporation, medical service corporation or health care center
419 delivering, issuing for delivery, renewing, continuing or amending any
420 long-term care policy in this state shall, upon receipt of a written
421 authorization executed by the insured, (i) disclose information to a
422 managed residential community for the purpose of determining such
423 insured's eligibility for an insurance benefit or payment, and (ii) provide
424 a copy of the initial acceptance or declination of a claim for benefits to
425 the managed residential community at the same time such acceptance
426 or declination is made to the insured.

427 (b) (1) No insurance company, fraternal benefit society, hospital
428 service corporation, medical service corporation or health care center
429 may deliver or issue for delivery any long-term care policy or certificate
430 that has a loss ratio of less than sixty-five per cent for any group long-
431 term care policy. An issuer shall not use or change premium rates for a
432 long-term care policy or certificate unless the rates have been filed with
433 the [Insurance Commissioner] commissioner. Deviations in rates to
434 reflect policyholder experience shall be permitted, provided each policy
435 form shall meet the loss ratio requirement of this section. Any rate filings
436 or rate revisions shall demonstrate that anticipated claims in relation to
437 premiums when combined with actual experience to date can be
438 expected to comply with the loss ratio requirement of this section. On
439 an annual basis, an insurer shall submit to the [Insurance
440 Commissioner] commissioner an actuarial certification of the insurer's
441 continuing compliance with the loss ratio requirement of this section.
442 Any rate or rate revision may be disapproved if the commissioner
443 determines that the loss ratio requirement will not be met over the
444 lifetime of the policy form using reasonable assumptions.

445 (2) (A) Any insurance company, fraternal benefit society, hospital
446 service corporation, medical service corporation or health care center
447 that files a rate filing for an increase in premium rates for a long-term
448 care policy [that] shall send a notice to its certificate holders, not later
449 than the date on which such company, society, corporation or center
450 files such rate filing and in at least twelve-point font, disclosing that
451 such company, society, corporation or center has filed such rate filing
452 and the manner in which its certificate holders may participate in the
453 premium rate approval process. If an insurance company, fraternal
454 benefit society, hospital service corporation, medical service corporation
455 or health care center files a rate filing for an increase in premium rates
456 for a long-term care policy that is for twenty per cent or more, such
457 company, society, corporation or center shall spread the increase over a
458 period of not less than three years and not file a rate filing for an increase
459 in premium rates for the long-term care policy during the period chosen.
460 Such company, society, corporation or center shall use a periodic rate

461 increase that is actuarially equivalent to a single rate increase and a
462 current interest rate for the period chosen.

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

465 (i) Notify its certificate holders of such premium rate increase and
466 make available to such certificate holders the additional choice of
467 reducing the policy benefits to reduce the premium rate or electing
468 coverage that reflects the minimum set of affordable benefit options
469 developed by the commissioner pursuant to section 2 of this act. Such
470 notice shall include a description of such policy benefit reductions and
471 minimum set of affordable benefit options. The premium rates for any
472 benefit reductions shall be based on the new premium rate schedule;

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

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

483 (c) (1) (A) No such company, society, corporation or center may
484 deliver or issue for delivery any long-term care policy without
485 providing, at the time of solicitation or application for purchase or sale
486 of such coverage: []

487 (i) A full and fair written disclosure of the benefits and limitations of
488 the policy; and

489 (ii) A consultation with an insurance producer licensed in this state
490 concerning the benefits and limitations of the policy and, unless the

491 policy is a policy for which no premium rate revision or rate schedule
492 increases can be made, the possibility that the policy may be subject to
493 rate increases in the future.

494 (B) The provisions of this subsection shall not be applicable to
495 noncontributory plans.

496 (2) (A) The applicant shall sign an acknowledgment at the time of
497 application for such policy that the company, society, corporation or
498 center has provided to the applicant the written disclosure required
499 under this subsection [to the applicant] and the consultation with an
500 insurance producer licensed in this state required under subparagraph
501 (A)(ii) of subdivision (1) of this subsection. If the method of application
502 does not allow for such signature at the time of application, the
503 applicant shall sign such acknowledgment not later than at the time of
504 delivery of such policy.

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

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

511 (i) A statement that the policy may be subject to rate increases in the
512 future and a projection of future rates for at least the next ten years;

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

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

520 (iv) An explanation of how a premium rate or rate schedule revision

521 will be applied that includes a description of when such rate or rate
522 schedule revision will be effective; and

523 (v) Information regarding each premium rate increase, if any, over
524 the past ten years on such policy form [or] and not more than two similar
525 policy forms for this state or any other state, that identifies, at a
526 minimum, (I) the policy forms for which premium rates have been
527 increased, (II) the calendar years when each such policy form was
528 available for purchase, and (III) the amount or percentage of each
529 increase. The percentage may be expressed as a percentage of the
530 premium rate prior to the increase or as minimum and maximum
531 percentages if the rate increase is variable by rating characteristics.

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

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

540 (B) If an acquiring company, society, corporation or center files a
541 request for a premium rate increase on or before January 1, 2015, or the
542 end of a twenty-four-month period after the acquisition, whichever is
543 later, for a block of policy forms or long-term care policies acquired from
544 a nonaffiliated company, society, corporation or center such acquiring
545 company, society, corporation or center may exclude from the
546 disclosure required under subdivision (3) of this subsection such
547 premium rate increase, except that the nonaffiliated company, society,
548 corporation or center selling such block of policy forms or long-term
549 care policies shall include such premium rate increase in such
550 disclosure.

551 (C) If an acquiring company, society, corporation or center under
552 subparagraph (B) of this subdivision files a subsequent request, even

553 within the twenty-four-month period specified in said subparagraph,
554 for a premium rate increase on the same block of policy forms or long-
555 term care policies set forth in said subparagraph, the acquiring
556 company, society, corporation or center shall include in the disclosure
557 required under subdivision (3) of this subsection such premium rate
558 increase and any premium rate increase filed and approved pursuant to
559 subparagraph (B) of this subdivision.

560 (d) The [Insurance Commissioner] commissioner shall adopt
561 regulations, in accordance with chapter 54, that address (1) the insured's
562 right to information prior to his replacing an accident and sickness
563 policy with a long-term care policy, (2) the insured's right to return a
564 long-term care policy to the insurer, within a specified period of time
565 after delivery, for cancellation, and (3) the insured's right to accept by
566 the insured's signature, and prior to it becoming effective, any rider or
567 endorsement added to a long-term care policy after the issuance date of
568 such policy, provided (A) any regulations adopted pursuant to
569 subdivisions (1) and (2) of this subsection shall not be applicable to (i)
570 any long-term care policy that is delivered or issued for delivery to one
571 or more employers or labor organizations, or to a trust or to the trustees
572 of a fund established by one or more employers or labor organizations,
573 or a combination thereof or for members or former members or a
574 combination thereof, of the labor organizations, or (ii) noncontributory
575 plans, and (B) any regulations adopted pursuant to subdivision (3) of
576 this subsection shall not be applicable to any group long-term care
577 policy. The [Insurance Commissioner] commissioner shall adopt such
578 additional regulations as the commissioner deems necessary in
579 accordance with said chapter 54 to carry out the purpose of this section.

580 (e) The [Insurance Commissioner] commissioner may, upon written
581 request by any such company, society, corporation or center, issue an
582 order to modify or suspend a specific provision of this section or any
583 regulation adopted pursuant thereto with respect to a specific long-term
584 care policy upon a written finding that: (1) The modification or
585 suspension would be in the best interest of the insureds; (2) the purposes
586 to be achieved could not be effectively or efficiently achieved without

587 such modification or suspension; and (3) (A) the modification or
588 suspension is necessary to the development of an innovative and
589 reasonable approach for insuring long-term care, (B) the policy is to be
590 issued to residents of a life care or continuing care retirement
591 community or other residential community for the elderly and the
592 modification or suspension is reasonably related to the special needs or
593 nature of such community, or (C) the modification or suspension is
594 necessary to permit long-term care policies to be sold as part of, or in
595 conjunction with, another insurance product. Whenever the
596 commissioner decides not to issue such an order, the commissioner shall
597 provide written notice of such decision to the requesting party in a
598 timely manner.

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

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

611 (h) Notwithstanding any provision of the general statutes, the
612 commissioner shall, at least annually, examine the books and records of
613 each insurance company, fraternal benefit society, hospital service
614 corporation, medical service corporation or health care center
615 delivering, issuing for delivery, renewing, continuing or amending any
616 long-term care policy in this state to ensure the solvency of such
617 company, society, corporation or center.

618 Sec. 5. Section 3-123g of the general statutes is repealed and the

619 following is substituted in lieu thereof (*Effective July 1, 2021*):

620 (a) The Comptroller shall publish in a newspaper, having a
621 substantial circulation in the state, a notice of intent to issue a payroll
622 deduction slot. For the purposes of this section, "payroll deduction slot"
623 means an automatic periodic deduction from a state payroll check. Any
624 person interested in submitting proposals in response to such notice
625 shall submit, within thirty days of such notice, the following
626 information, in writing, to the Comptroller: (1) The name and mailing
627 address of the applicant; (2) a detailed description of the product or
628 service which the applicant intends to market to state employees; (3) the
629 name, address and telephone number of any agent of the applicant from
630 whom interested persons may obtain copies of the application; (4)
631 detailed information on the financial ability of the applicant; (5) detailed
632 information on past performance; and (6) such additional information
633 as the Comptroller, or, if the product is a long-term care insurance
634 product, the Insurance Commissioner in consultation with the executive
635 director of the Office of Health Strategy, deems necessary. For the
636 purposes of this section, "applicant" means any person who requests to
637 establish or renew a payroll deduction slot under this section.

638 (b) (1) [Upon the receipt of such proposals] Except as provided in
639 subdivision (2) of this subsection, the Comptroller shall, upon receipt of
640 such proposals, submit any such proposals to the Vendor Advisory
641 Committee for review. The Vendor Advisory Committee shall consist of
642 a designee of the Comptroller, the Labor Commissioner or his designee,
643 the Insurance Commissioner or his designee, and three representatives
644 of labor unions representing state employees appointed by the
645 Comptroller in consultation with the state employee unions. Such
646 representatives of labor unions shall serve five-year terms and shall not
647 serve successive terms. The Vendor Advisory Committee shall review
648 such proposals and make recommendations to the Comptroller whether
649 to approve or disapprove such proposals. Prior to approving any
650 payroll deduction slot under this section, the Comptroller shall consider
651 the following criteria: [(1)] (A) The benefit to state employees of the
652 product or service; [(2)] (B) the price or rate of the product or service;

653 [(3)] (C) the skill, ability and integrity of the applicant to deliver such
654 product or service; [(4)] (D) the past performance of the applicant; [(5)]
655 (E) the recommendations of the Vendor Advisory Committee; and [(6)]
656 (F) any other information which the Comptroller, or, if the product is a
657 long-term care insurance product, the Insurance Commissioner in
658 consultation with the executive director of the Office of Health Strategy,
659 deems necessary. In considering the past performance of the applicant,
660 the Comptroller shall evaluate the skill, ability and integrity of the
661 applicant in terms of the applicant's fulfillment of past contract
662 obligations and his experience or lack of experience in delivering the
663 same or similar products or services.

664 (2) On and after July 1, 2021, the Comptroller shall, upon receipt of
665 an applicant's proposal to establish or renew a payroll deduction slot
666 under this section for a long-term care insurance product, submit such
667 proposal to the Insurance Department and the Office of Health Strategy
668 for review. The Insurance Commissioner, in consultation with the
669 executive director of the Office of Health Strategy, shall review such
670 proposal to determine whether the applicant is adequately capitalized
671 and solvent, the premium rates for the long-term care insurance product
672 are stable and the long-term care insurance product is appropriate for
673 state employees. If the Insurance Commissioner, in consultation with
674 the executive director of the Office of Health Strategy, determines that
675 the applicant and long-term care insurance product satisfy the criteria
676 established in this subdivision, the Insurance Commissioner shall
677 submit the proposal to the vendor Advisory Committee for review
678 under subdivision (1) of this subsection.

679 (c) Any payroll deduction slot approved by the Comptroller shall be
680 in the form of a written agreement, approved by the Attorney General,
681 specifying the terms and conditions for the use of such slot, and shall be
682 for a fixed term, not to exceed five years.

683 (d) The Comptroller may issue a payroll deduction slot in accordance
684 with the procedures of this section. The Comptroller may adopt
685 regulations in accordance with the provisions of chapter 54 to

686 implement the provisions of this section.

687 (e) On July 1, 1997, and every two years thereafter, the Comptroller
 688 shall submit to the General Assembly a report on the number and type
 689 of products and services offered through payroll deduction slots and the
 690 number of state employees who are utilizing such products and
 691 services."

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>July 1, 2021</i>	3-123g