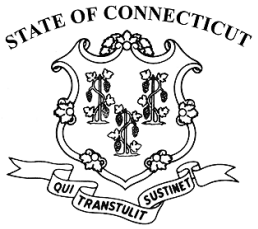

Senate Bill No. 1046

Public Act No. 21-150

AN ACT CONCERNING LONG-TERM CARE INSURANCE.

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

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 Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2022*):

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

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

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

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

(4) "Commissioner" means the Insurance Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall, after consulting with other state governments and conducting a nation-wide review, develop and prescribe a minimum set of affordable benefit options to be offered by an insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center that files a rate filing under section 38a-501 of the general statutes, as amended by this act, or section 38a-528 of the general statutes, as amended by this

act, for an increase in premium rates for a long-term care policy that is for twenty per cent or more. The commissioner shall send to each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center that files such a rate filing a notice disclosing such minimum set of affordable benefit options.

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

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

(a) (1) As used in this section and section 2 of this act, "long-term care policy" means any individual health insurance policy delivered or issued for delivery to any resident of this state on or after July 1, 1986, that is designed to provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after an elimination period (A) not to exceed one hundred days of confinement, or (B) of over one hundred days but not to exceed two years of confinement, provided such period is covered by an irrevocable trust in an amount estimated to be sufficient to furnish coverage to the grantor of the trust for the duration of the elimination period. Such trust shall create an unconditional duty to pay the full amount held in trust exclusively to cover the costs of confinement during the elimination period, subject only to taxes and any trustee's charges allowed by law. Payment shall be made directly to the provider. The duty of the trustee may be enforced by the state, the grantor or any person acting on behalf of the grantor. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) (A) Any such company, society, corporation or center may

exclude from the disclosure required under subparagraph (B) of subdivision (2) of this subsection premium rate increases that only apply to blocks of business or long-term care policies acquired from a nonaffiliated company, society, corporation or center and that occurred prior to the acquisition.

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

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

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

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

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

(f) The **[**Insurance Commissioner**]** commissioner may, upon written request by any such company, society, corporation or center, issue an

order to modify or suspend a specific provision of this section or any regulation adopted pursuant thereto with respect to a specific long-term care policy upon a written finding that: (1) The modification or suspension would be in the best interest of the insureds; (2) the purposes to be achieved could not be effectively or efficiently achieved without such modification or suspension; and (3) (A) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care, (B) the policy is to be issued to residents of a life care or continuing care retirement community or other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such community, or (C) the modification or suspension is necessary to permit long-term care policies to be sold as part of, or in conjunction with, another insurance product. Whenever the commissioner decides not to issue such an order, the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

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

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

Sec. 4. Section 38a-528 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective January 1, 2022*):

(a) (1) As used in this section and section 2 of this act, "long-term care policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of this state on or after July 1, 1986, that is designed to provide, within the terms and conditions of the policy or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" does not include any such policy or certificate that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

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

[(2) (A)**]** (B) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any

long-term care policy in this state may refuse to accept, or refuse to make reimbursement pursuant to, a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

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

(b) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy or certificate that has a loss ratio of less than sixty-five per cent for any group long-term care policy. An issuer shall not use or change premium rates for a long-term care policy or certificate unless the rates have been filed with the **[**Insurance Commissioner**]** commissioner. Deviations in rates to reflect policyholder experience shall be permitted, provided each policy form shall meet the loss ratio requirement of this section. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. On an annual basis, an insurer shall submit to the **[**Insurance Commissioner**]** commissioner an actuarial certification of the insurer's

continuing compliance with the loss ratio requirement of this section. Any rate or rate revision may be disapproved if the commissioner determines that the loss ratio requirement will not be met over the lifetime of the policy form using reasonable assumptions.

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

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

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

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

(iii) Include a statement in such notice that if a certificate holder fails to elect a reduction in policy benefits or coverage that reflects the

minimum set of affordable benefit options developed by the commissioner pursuant to section 2 of this act by the end of the notice period and has not cancelled the policy, the certificate holder will be deemed to have elected to retain the existing policy benefits.

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

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

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

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

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

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

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

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

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

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

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

(B) If an acquiring company, society, corporation or center files a request for a premium rate increase on or before January 1, 2015, or the end of a twenty-four-month period after the acquisition, whichever is later, for a block of policy forms or long-term care policies acquired from a nonaffiliated company, society, corporation or center such acquiring

company, society, corporation or center may exclude from the disclosure required under subdivision (3) of this subsection such premium rate increase, except that the nonaffiliated company, society, corporation or center selling such block of policy forms or long-term care policies shall include such premium rate increase in such disclosure.

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

(d) The **[**Insurance Commissioner**]** commissioner shall adopt regulations, in accordance with chapter 54, that address (1) the insured's right to information prior to his replacing an accident and sickness policy with a long-term care policy, (2) the insured's right to return a long-term care policy to the insurer, within a specified period of time after delivery, for cancellation, and (3) the insured's right to accept by the insured's signature, and prior to it becoming effective, any rider or endorsement added to a long-term care policy after the issuance date of such policy, provided (A) any regulations adopted pursuant to subdivisions (1) and (2) of this subsection shall not be applicable to (i) any long-term care policy that is delivered or issued for delivery to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof or for members or former members or a combination thereof, of the labor organizations, or (ii) noncontributory plans, and (B) any regulations adopted pursuant to subdivision (3) of

this subsection shall not be applicable to any group long-term care policy. The **[**Insurance Commissioner**]** commissioner shall adopt such additional regulations as the commissioner deems necessary in accordance with said chapter 54 to carry out the purpose of this section.

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

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

of such decision to the requesting party in a timely manner.

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

Approved July 7, 2021