Connecticut Life and Health Insurance Law Supplement Update

Effective September 1, 2021

Licensing Definitions and Information section, Insurer heading: Add the following at the end of this section:

A **reinsurance contract** is considered to be an insurance contract, but the hazard under these contracts is declared to be distinct in nature from the hazard originally insured. No provision of law pertaining to the form of insurance contracts applies to reinsurance contracts unless the law specifically states otherwise.

Licensing Definitions and Information section, Suspension and revocation heading: Add the following material after this section.

Denial of producer license

The Commissioner may deny an application for an insurance producer license if they determine the applicant is not properly qualified or trustworthy and that granting the license is against the public interest.

Producer Regulation section, Misrepresentation, twisting heading: Add the following at the end of this section:

It is also considered misrepresentation to make false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer or individual.

Producer Regulation section, Appointment of producer as agent heading: Add the following after this heading:

Allowable compensation

Insurance producers may not receive any form of compensation other than commissions from insureds unless the compensation is based on a written agreement that specifies the amount of compensation. This agreement must be signed by the insured.

The Commissioner may establish a reasonable schedule of maximum fees that may be charged by insurance producers, or they may regulate such fees on an individual basis.

If an insurance producer receives any compensation directly from a customer for the initial placement of insurance, the producer may not accept or receive any compensation from an insurer for that placement of insurance unless the producer has, prior to the time the policy is delivered to the customer, done the following:

- Obtained the customer's documented acknowledgment that such compensation will be received by the producer
- Disclosed the amount of compensation that the producer will receive from the insurer or other third party for the placement

Termination of appointment and agency contracts

Any insurance company authorized to transact fire or casualty business in Connecticut must, upon termination of a producer's appointment, allow all contracts written by that producer to be renewed for 18 months following the date of termination. However, if the policy does not meet the company's underwriting guidelines, it must give 60 days' notice to the producer that the contract will not be renewed. This 60-day period may be reduced if the Commissioner determines it is necessary to protect the insured or the insurance company's solvency.

During the renewal periods, the producer must be paid the same commission that would have been paid during the twelve months immediately preceding the notice of termination.

If the insurer is terminating an appointment, it must provide at least 90 days' notice of termination to the producer. During this 90-day period, the producer cannot write or bind any new business for the insurer without the written approval of the insurer.

Connecticut Life and Health Insurance Guaranty Association section, Prohibited advertising of Life and Health Insurance Guaranty Association heading: Add the following material after this heading:

Brokered transactions guaranty funds

The Brokered Transactions Guaranty Fund pays up to $10,000 to Connecticut residents who have lost money or property due to embezzlement, false pretenses, artifice, trickery, forgery, fraud, misrepresentation, or deceit committed by a licensed insurance producer or an unlicensed person acting as a producer.

Protection of Personal Information in Case of Data Breach section, Information security program heading: Add the following new section after this heading.

Form Filing Requirements

Filing and approval procedures: life and individual health insurance

Insurers that are required to file policy forms with the Commissioner must comply with the following standards.

Filings must be done electronically through the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). If one or more elements within a filing vary by member company within a group of companies, separate filings must be submitted for each insurer within the group.

The electronic filing must contain a brief description of the type of filing and any applicable form identification number.

All SERFF submissions must include the following information in the filing description:

- List of documents submitted
- Brief outline of proposed changes
- Approval sought
- Proposed effective date
- Whether the form is subject to the state's Insurance Plain Language Act

Every form filing must be completed in "John Doe" fashion. If the form is subject to the Insurance Plain Language Act, the filing must include a certificate signed by an officer of the insurer attesting to this fact.

Each form filing, other than those involving group life, group annuities, and group accident and health insurance, must be accompanied with the rates that will be used in connection with the form.

When an insurer makes reference to another document in its filing, it must include a copy or provide the tracking number for the referenced document.

All filings must be state specific. Only filings with state specific language will be approved.

Within 90 days after a form is accepted for review, the Department will review the form and either approve or disapprove it. If additional information is necessary to determine if the form is acceptable, the Department will ask the insurer to provide this information. The insurer will have 10 calendar days from the date of the request to provide the additional information. If the insurer fails to comply with the request within the allotted time, it will be deemed to have voluntarily withdrawn its filing and the Department will close its file without further action.

The Commissioner will disapprove the use of any form if it does not comply with the provisions of this regulation or any other provision of law, or if it contains provisions that are unfair or deceptive or that encourage misrepresentation of the policy. The reason for disapproval will be specified.

Filing and approval procedures: group health insurance

The form filing requirements for group health insurance forms are very similar to those just described for life and individual health insurance forms.

Group health insurance form filings must include a filing transmittal letter sent to the attention of the Life and Health Division of the Insurance Department.

If one or more elements within a filing vary by member company within a group of companies, separate filing transmittal letters must be submitted for each insurer within the group.

The filing transmittal letter must contain a descriptive caption that identifies the insurer, provides a brief description of the type of filing, and any applicable form identification number. The body of the filing transmittal letter must provide the following information:

- List of documents submitted
- Brief outline of proposed changes
- Approval sought
- Proposed effective date
- Whether the form is subject to the state's Insurance Plain Language Act

The filing must also include a separate document disclosing the intended use of the form and the method it will be marketed. This document must include the following:

- Information on how the form will be marketed (i.e. individual basis, mass merchandised, association membership, union membership, etc.)
- Market for which the form is intended (especially note markets such as over age 65, key person, professionals, etc.)
- Underwriting basis used, in particular any deviation from standard underwriting rules
- Any limitation of the use of the form by certain agents or brokers
- Explanation of any change in benefits that occur while the contract is in force
- Notation and explanation of any deviation from the insurer's usual retention

Every form filing must be completed in "John Doe" fashion. If the form is subject to the Insurance Plain Language Act, the filing must include a certificate signed by an officer of the insurer attesting to this fact.

When an insurer makes reference to another document in its filing, it must include a copy or provide the tracking number for the referenced document.

Within 15 days of receipt of a form filing, the Insurance Department will determine if the filing is complete or deficient for purposes of submission for review and will issue written notice to the insurer regarding the status of the form. If the filing is deficient, the notice will indicate the specific items that must be corrected.

Within 75 days after a form is accepted for review, the Department will review the form and either record it effective or disapprove it. If additional information is necessary to determine if the form is acceptable, the Department will ask the insurer to provide this information. The insurer will have 30 calendar days from the date of the request to provide the additional information. If the insurer fails to comply with the request within the allotted time, it will be deemed to have voluntarily withdrawn its filing and the Department will close its file without further action.

Policy Clauses and Provisions section, Interest on proceeds heading: Add the following material at the end of this section.

Interest rates

Life insurance policies may provide loan interest rates of up to 8% per year. Adjustable interest rates are also permitted if they are calculated in accordance with applicable laws.

Policy provisions pertaining to beneficiaries

A beneficiary's proceeds from a life insurance policy are protected against the claims of creditors unless the policy was procured with the intent to defraud creditors.

A trustee may be named as a policy beneficiary.

Other General Provisions section, Exclusions from coverage heading: Add the following material after this heading.

Preexisting conditions provisions

Individual and group health insurance plans may not impose a preexisting condition provision on any individual.

Insurance companies may not refuse to issue individual health insurance coveragel solely on the basis that the individual has a preexisting condition.

Connecticut Mandated Benefits And Offers Of Coverage For Individual And Group Policies, Infertility coverage heading: Add the following after this heading:

Chiropractic coverage

Individual health insurance policies must provide coverage for services rendered by a licensed chiropractor to the same extent coverage is provided for services rendered by a physician. The services must be used to treat a condition covered under the policy and within services a chiropractor is licensed to perform.

Coverage for mammograms

Individual health insurance policies must provide benefits for mammograms to any woman covered under the policy that are at least equal to the following:

- A baseline mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, for any woman who is 35 to 39 years old; and
- A mammogram, which may be provided by breast tomosynthesis at the option of the woman covered under the policy, every year for any woman who is 40 or older

The policy must provide additional benefits as follows.

- Comprehensive ultrasound screening of the breasts if:
  - A mammogram demonstrates heterogeneous or dense breast tissue
  - A woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing, or other indications as determined by a woman's physician
  - The screening is recommended by a woman's treating physician for a woman who is 40 or older and has a family history or prior personal history of breast cancer or prior personal history of breast disease diagnosed through biopsy as benign
- Magnetic resonance imaging of the breasts under guidelines established by the American Cancer Society

(page 103) Group Insurance section: Add the following at the beginning of this section:

Required provisions

Group health insurance policies must include a renewal, continuation, or non-renewal provision. This provision must be appropriately captioned, appear on the first page of the policy, and clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

Except for riders or endorsements by which the insurer makes a change requested by the policyholder, or exercises a specifically reserved right under the policy or certificate, all riders or endorsements added to a policy or certificate after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage require signed acceptance by the policyholder. After the policy is issued, any rider or endorsement that increases benefits or coverage with a corresponding increase in premium requires signed acceptance by the policyholder, unless the increase is required by law.

A policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," "maximum allowable charge," or words of similar import must include definitions of those terms.

Medicare Supplement Policies section, Open enrollment heading: Add the following material after this heading:

Definitions

Definitions for certain terms in Medicare Supplement policies must meet the requirements described in this section.

Accident, accidental injury, or **accidental means** must be defined to employ "result" language and may not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words.

The definition may not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

Sickness may not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

Long-Term Care Insurance, Definition heading: Replace the material under this heading with the following content.

Definitions

LTC insurance is any policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Some insurer offer a discount if both spouses purchase a policy.

Long-term care policies issued in Connecticut must use the following definitions.

Activities of daily living means activities such as, for example, bathing, dressing, eating, toileting, and transferring from bed to chair.

Home health care services may not be defined more restrictively than medical and non-medical services, provided to ill, disabled, or infirm persons who reside at home. Examples of these services include homemaker/home health aide services, personal care services, adult day care, respite care services, and hospice care services.

Mental or nervous disorders may not be defined more restrictively than a definition including neuroses, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, except that Alzheimers disease may not be considered a mental or nervous disorder.

Long-Term Care Insurance, Definitions heading: add the following after this heading:

Minimum requirements

Long-term care policies must meet the minimum standards described in this section.

Benefits may not be conditional on prior hospitalization or institutionalization.

Policies cannot have an elimination period longer than 100 days of confinement.

The policy may not deny a claim for loss that begins more than six months from the effective date of the policy for a pre-existing condition. A pre-existing condition may not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

Policies must make reasonable provision for waiver of premium. As to benefits for institutional confinement, this requirement is met if the policy provides for a waiver of premium after benefits have been paid for 90 consecutive days and thereafter during the continuance of the consecutive days for which benefits are paid.

Policies may exclude loss caused by mental disease or disorder without demonstrable organic disease.

A policy that provides benefits for home health care may not limit or exclude such benefits by:

- requiring that the insured would need skilled care in a skilled nursing facility if home care services were not provided;
- requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;
- limiting eligible services to services provided by registered nurses or licensed practical nurses;
- requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other home care worker acting within the scope of their licensure;
- excluding coverage for personal care services provided by a home health aide;
- requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;
- requiring that the insured have an acute condition before home healthcare services are covered;
- limiting benefits to services provided by Medicare certified agencies or providers; and
- excluding coverage for adult day care, hospice care, skilled nursing care, or physical, occupational, respiratory or speech therapy.

Long-Term Care Insurance, Connecticut Partnership for Long-Term Care: Add the following content at the end of this section.

Before a producer can market, discuss or sell any Partnership-approved long-term care insurance policy in Connecticut, they must have met the training requirements and get certified under the Partnership's

Certification Training program. Certification training is available to Life, Accident and Health producers who have a valid license in Connecticut and **i**s required for both resident and non-resident producers who wish to market Partnership-approved policies. The training is a one-time requirement, no renewal training is required.

Miscellaneous Laws and Regulations Pertinent to Health Insurance: Add the following to the end of this section.

Subrogation

Subrogation is the transfer of the insured's right of recovery against others to the insurance company. The subrogation provision may also be called **transfer of right of recovery against others to us**. Insurance companies have a legal right to sue a third party that has caused an insurance loss to the insured. For example, if an insured suffers a health insurance loss caused by a third party, the insurance company may pay the insured's covered medical costs according to the benefit plan. Using subrogation, the insurance carrier then brings suit against the negligent party or their insurance company to recover the amount paid to the insured for the loss.