House of Representatives

General Assembly

File No. 650

January Session, 2025

House Bill No. 7226

House of Representatives, April 10, 2025

The Committee on Government Administration and Elections reported through REP. BLUMENTHAL of the 147th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING LONG-TERM CARE INSURANCE AND ELIGIBILITY FOR STATE CONTRACTS.

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

Section 1. (NEW) (*Effective January 1, 2026*) The Insurance Department shall hold a public hearing for long-term care premium rate increase requests that exceed ten per cent. Any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center that requests such premium rate increase shall provide each policyholder with advance written notice of the date and time of such hearing not less than fourteen days in advance of such date.

Sec. 2. (NEW) (*Effective January 1, 2026*) 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, 2026, unless such insurance company, fraternal benefit society, hospital service corporation, medical service corporation or

health care center provides written notice to an individual prior to the purchase of any long-term care policy of the risk of future premium rate increases.

Sec. 3. Subsection (b) of section 38a-501 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(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 commissioner. Any rate filings or rate revisions shall (A) 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, and (B) certify that the increase is necessary to prevent a material risk of insolvency. 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 38a-475a. 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 38a-475a; 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 38a-475a 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.

Sec. 4. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "State agency" means any office, department, board, council, commission, institution or other agency in the executive, legislative or judicial branch of state government;

(2) "State contract" means an agreement or a combination or series of agreements between a state agency and a person, firm or corporation, having a total value of more than one hundred thousand dollars in a calendar or fiscal year, for (A) a project for the construction, alteration or repair of any public building or public work, (B) services, including, but not limited to, consulting and professional services, (C) the procurement of supplies, materials or equipment, (D) a lease, or (E) a licensing arrangement. "State contract" does not include a contract between a state agency or a quasi-public agency and a political subdivision of the state;

(3) "Insurer" means any insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center; and

(4) "Principals and key personnel" means officers, directors, shareholders, members, partners and managerial employees.

(b) On and after October 1, 2025, no state agency shall execute a state contract with an insurer unless such contract contains the representation described in this section.

(c) Any principal or key personnel of the insurer submitting a bid or proposal for a state contract shall represent that no such principals and key personnel of the insurer, or agent of such insurer, has been found in violation of section 1 or 2 of this act or subsection (b) of section 38a-501 of the general statutes, as amended by this act, during the immediately preceding five years.

(d) Any bidder or proposer that does not agree to the representations required under this section shall be rejected and the state agency shall award the contract to the next highest ranked proposer or the next lowest responsible qualified bidder or seek new bids or proposals.

(e) Each state agency shall include in the bid specifications or request for proposals for a state contract a notice of the representation requirements of this section.

(f) The Insurance Commissioner and the Commissioner of Administrative Services shall enter into a memorandum of understanding concerning the sharing of information to enable the Commissioner of Administrative Services to verify a representation made under this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2026*	New section
Sec. 2	*January 1, 2026*	New section

Sec. 3	*January 1, 2026*	38a-501(b)
Sec. 4	*January 1, 2026*	New section

GAE *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 26 $	FY 27 $
Insurance Dept.	IF - Cost	70,700	137,600

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill makes changes regarding long-term care insurance and state contracting, which result in a cost to the Insurance Fund of $70,700 in FY 26 and $137,600 in FY 27 and annually thereafter.

Section 1 requires the Insurance Department to hold a public hearing when a long-term care insurer is requesting a rate increase above 10%, resulting in a cost to the Insurance Fund of $70,700 in FY 26 and $137,600 in FY 27 and annually thereafter. It is anticipated that the department will need to hold approximately 40 public hearings a year, and handling this volume will require one new staff position.

The department is expected to hire one full-time Paralegal with an annualized salary of $75,000 and fringe benefits of $62,400. FY 26 personnel costs are expected to be $37,500 and $31,200 respectively, reflecting the section's January 1, 2026 effective date. Other expenses for the new position are expected to total $2,000 in FY 26 for a laptop and related supplies, and $200 annually beginning in FY 27 for office supplies.

Sections 2 and 3 require long-term care insurers to make certain

procedural changes that have no fiscal impact to the state.

Section 4 prohibits the state from entering into a contract with an insurer unless they have met certain requirements which results in no fiscal impact to the state.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

HB 7226

AN ACT CONCERNING LONG-TERM CARE INSURANCE AND ELIGIBILITY FOR STATE CONTRACTS.

SUMMARY

This bill makes various changes affecting long-term care (LTC) insurance policy rate increases (see BACKGROUND) and state contracts with insurers. It applies to insurance companies, fraternal benefit societies, hospital and medical service corporations, and HMOs ("insurers").

For LTC insurance premium rate increases, the bill does the following:

1. requires the Insurance Department to hold a hearing for any LTC premium rate increase request above 10% and insurers to notify policyholders about the hearing date and time at least 14 days in advance (§ 1);

2. starting January 1, 2026, prohibits insurers from delivering, issuing, renewing, continuing, or amending an LTC policy in the state unless they give advanced written notice to someone before they purchase the policy about the risk of future premium rate increases (§ 2); and

3. requires rate filings for individual LTC policies to certify that the increase is necessary to prevent a material risk of insolvency (§ 3).

Additionally, starting October 1, 2025, the bill prohibits state agencies from executing state contracts with health insurers unless the insurer represents in the contract that it has not violated (1) the bill's hearing and notification requirements for LTC premium rate increases or (2)

existing law's rate filing requirements for individual LTC policies.

Correspondingly, the bill requires the insurance and administrative services commissioners to enter into a memorandum of understanding to share information that enables the administrative services commissioner to verify the representations insurers made in these contracts.

EFFECTIVE DATE: January 1, 2026

INDIVIDUAL LTC POLICIES

Under existing law, insurers cannot use or change premium rates for individual LTC policies without filing the rates with the insurance commissioner for approval. These rate filings must demonstrate that anticipated claims in relation to premiums, combined with actual experience, will meet the law's required minimum loss ratio of 60%. (This means that for every dollar of premium collected, the insurer must spend at least 60 cents on claim payments.)

The bill additionally requires the rate filings to certify that the increase is necessary to prevent a material risk of insolvency.

REQUIRED REPRESENTATIONS IN STATE CONTRACTS

State Contract Definition

Under the bill, a "state contract" is an agreement (or a combination or series of them) between a state agency and a person, firm, or corporation, with a total value of more than $100,000 in a calendar or fiscal year, for the following:

1. a project to construct, alter, or repair any public building or public work;

2. services, including consulting and professional services;

3. procuring supplies, materials, or equipment; or

4. a lease or licensing arrangement.

It does not include a contract between a state agency or a quasi-public agency and a political subdivision of the state.

Required Representations

Starting October 1, 2025, the bill prohibits state agencies from executing a contract with an insurer, unless the insurer's principals or key personnel (e.g., officers, directors, or shareholders) represent in the contract that, during the previous five years, they or the insurer's agent have not violated (1) the bill's hearing and disclosure requirements for LTC policy rate increases or (2) existing law's rate filing requirements for individual LTC policies.

Bidders and Proposers

The bill requires state agencies to include in the bid specifications or request for proposals for a state contract a notice of the bill's representation requirements.

Under the bill, a state agency must reject a bidder or proposer that does not agree to these representations and (1) award the contract to the next highest ranked proposer or next lowest responsible qualified bidder or (2) seek new bids or proposals.

BACKGROUND

Long-Term Care Policies

By law, individual or group LTC insurance policies generally provide benefits for treating an injury, illness, or loss of functional capacity in a setting other than an acute care hospital (e.g., a nursing home or the insured's home) for at least one year after a specified elimination period. An LTC policy does not include a policy that primarily provides Medicare supplemental coverage, disability income protection coverage, or major medical coverage, among other exclusions (CGS §§ 38a-501 & -528).

Related Bills

sSB 1269 (File 238), favorably reported by the Insurance and Real Estate Committee, caps, at 10%, the premium rate increases that LTC

insurers can request but prohibits them from filing a rate increase that exceeds the most recent calendar year average in the consumer price index for urban consumers if the policyholder has held the LTC policy for at least 15 years.

SB 1278 (File 284), favorably reported by the Aging Committee, creates a personal income tax deduction for LTC insurance premiums and requires LTC insurers, before implementing a premium rate increase of more than 10%, to hold a public hearing and notify policyholders about the hearing date and time at least 14 days in advance.

SB 1420 (File 381), favorably reported by the Human Services Committee, (1) restricts rate increases for Connecticut Partnership for Long-Term Care policies by prohibiting the insurance commissioner from approving rate increases greater than those allowed when the policy was precertified and (2) prohibits partnership policies from tying executive compensation to the state's approval of higher rates for policyholders.

sHB 7183 (File 520), favorably reported by the Government Oversight Committee, has substantially similar provisions that require (1) the insurance commissioner to hold a hearing for any LTC policy premium rate increase request above 10%, (2) health carriers to give LTC policyholders at least 14 days' advance notice of the hearing, and (3) health carriers to notify LTC policy purchasers of the risk of future premium increases.

COMMITTEE ACTION

Government Administration and Elections Committee

Joint Favorable
Yea 18 Nay 1 (03/26/2025)