Senate

General Assembly

File No. 283

January Session, 2025

Substitute Senate Bill No. 1269

Senate, March 27, 2025

The Committee on Insurance and Real Estate reported through SEN. CABRERA of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING LONG-TERM CARE INSURANCE.

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

Section 1. (*Effective from passage*) Not later than February 1, 2026, the Insurance Department shall prepare and submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall include an evaluation of an alternative pool for long-term care policyholders in excess of twenty years.

Sec. 2. Section 38a-458 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) As used in this section, "long-term care rider" means any provision or endorsement attached to any annuity contract or certificate that provides long-term care benefits for qualified long-term care services as provided in Section 7702B(c)(1) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time.

[(a)**]** (b) Provided such company is licensed for both life and health insurance in this state, any life insurance company doing business in this state may issue life insurance policies or certificates, or riders or endorsements thereto, that provide, within the terms and conditions of the policy or certificate, long-term care benefits as described in section 38a-501 or 38a-528, as amended by this act, except as specified in subsection **[**(c)**]** (d) of this section. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of this section.

[(b)**]** (c) (1) Provided such company is licensed for both life and health insurance in this state, any life insurance company doing business in this state may issue annuity contracts or certificates, or riders, including long-term care riders subject to the requirements of this subsection, and any applicable requirement under this title or any regulation adopted by the commissioner, in accordance with the provisions of chapter 54, or endorsements thereto, that provide, within the terms and conditions of the contract or certificate, long-term care benefits as described in section 38a-501 or 38a-528, as amended by this act, except as specified in subsection **[**(c)**]** (d) of this section, and that waive the surrender charges under such contract or accelerate a specified portion of the annuity value of such contract.

(2) Any life insurance company that issues any long-term care rider that provides long-term care benefits pursuant to subdivision (1) of this subsection shall provide each policyholder with a written disclosure for such long-term care rider that includes (A) the cost of such long-term care rider and any impact that such long-term care rider may have on the annuity contract's benefits, including, but not limited to, reductions in death benefits or surrender value, (B) any conditions or long-term care benefit triggers required by state or federal law, including, but not limited to, qualifying events, including an inability to perform at least two activities of daily living or such conditions related to severe cognitive impairment, and (C) any exclusions, limitations or coordination of benefits with other insurance coverage.

(3) Any life insurance company that issues any long-term care rider that provides long-term care benefits pursuant to subdivision (1) of this subsection shall (A) comply with any applicable requirement under this title concerning annuity contract suitability, long-term care insurance and disclosure requirements, (B) comply with any applicable requirements under federal law, including, but not limited to, tax-qualified long-term care policy requirements under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, (C) include nonforfeiture benefits required under this chapter and any applicable regulations adopted by the commissioner in accordance with the provisions of chapter 54, and (D) only provide coverage for long-term care rider benefits upon the occurrence of a qualifying event, as defined in the policy and required under this title, federal law and regulations adopted by the commissioner in accordance with the provisions of chapter 54.

(4) Any policyholder may cancel, without penalty, any such long-term care rider issued pursuant to subdivision (1) of this subsection not later than thirty days after receipt of such long-term care rider.

[(c)**]** (d) Long-term care benefits provided pursuant to subsection **[**(a)**]** (b) or **[**(b)**]** (c) of this section shall not be subject to the requirements of subsection (b) of section 38a-501, as amended by this act or subsection (b) of section 38a-528, as amended by this act.

[(d)**]** (e) No insurance producer shall sell any such policy, certificate, rider or endorsement unless the producer is licensed to sell both life and health insurance in this state.

[(e)**]** (f) A life insurance policy or annuity contract with long-term care benefits issued pursuant to this section may include a rider that provides long-term care benefits that become payable upon exhaustion of a specified amount of the death benefit under the life insurance policy or a specified amount of the annuity value of the annuity contract. Any elimination period limitations shall apply only to the acceleration phase of the life insurance policy or annuity contract to which the rider is attached. Such rider shall not contain an additional elimination period

and may calculate the waiver of premium from the time benefits are payable under such rider.

Sec. 3. Subsection (a) of section 38a-430 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) No life insurance or annuity policy or contract shall be delivered or issued for delivery to any person in this state, nor shall any application, rider, including a long-term care rider, as defined in section 38a-458, as amended by this act, or endorsement be used in connection therewith, until a copy of the form thereof shall have been filed with and approved by the commissioner. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a procedure for review of such policies and contracts. The commissioner shall issue an order disapproving the use of any such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy. The commissioner shall specify the reason for the commissioner's disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner.

Sec. 4. (NEW) (*Effective January 1, 2026, and applicable to taxable years commencing on or after January 1, 2026*) Any eligible taxpayer subject to the tax under chapter 229 of the general statutes shall be allowed a credit against the tax imposed under said chapter, other than the liability imposed under section 12-707 of the general statutes, in an amount equal to twenty per cent of the premiums paid by such eligible taxpayer during the taxable year for a long-term care policy, as defined in section 38a-501, as amended by this act, or 38a-528 of the general statutes, as amended by this act, for which the eligible taxpayer is the insured. As used in this section, (1) "eligible taxpayer" means any resident of this state with a federal adjusted gross income of less than two hundred thousand dollars, and (2) "resident of this state" has the same meaning as provided in section 12-701 of the general statutes.

Sec. 5. (*Effective from passage*) Not later than February 1, 2026, the Insurance Department shall prepare and submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall include an evaluation of the individual and group long-term care premium rate filing processes established under sections 38a-501, as amended by this act, and 38a-528 of the general statutes, as amended by this act.

Sec. 6. Section 38a-501 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) (1) As used in this section**,** **[**and section 38a-475a,**]** "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.

(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.

(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 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**]** Except as provided in subdivision (3) of this subsection, 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**]** shall not request in such filing an increase in premium rates for **[**the**]** such 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**]** that exceeds ten per cent.

(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.

(3) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of this subsection, 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 shall not request in such filing an increase in premium rates for such long-term care policy that exceeds the most recent calendar year average in the consumer price index for urban consumers, as published by the United States Department of Labor, Bureau of Labor Statistics, provided the policyholder of such long-term care policy has held such long-term care policy for not less than fifteen years.

(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 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 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 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 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 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 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. 7. Section 38a-528 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) (1) As used in this section**,** **[**and section 38a-475a,**]** "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.

(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.

(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 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 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**]** Except as provided in subdivision (3) of this subsection, 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**]** shall not request in such filing an increase in premium rates for **[**the**]** such 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**]** that exceeds ten per cent.

(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 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 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 38a-475a;**]** 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 38a-475a**]** 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.

(3) Notwithstanding the provisions of subparagraph (A) of subdivision (2) of this subsection, 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 shall not request in such filing an increase in premium rates for such long-term care policy that exceeds the most recent calendar year average in the consumer price index for urban consumers, as published by the United States Department of Labor, Bureau of Labor Statistics, provided the certificate holder of such long-term care policy has held such long-term care policy for not less than fifteen years.

(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 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 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 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 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 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**]** 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.

(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.

Sec. 8. Section 38a-475a of the general statutes is repealed. (*Effective January 1, 2026*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*January 1, 2026*	38a-458
Sec. 3	*January 1, 2026*	38a-430(a)
Sec. 4	*January 1, 2026, and applicable to taxable years commencing on or after January 1, 2026*	New section
Sec. 5	*from passage*	New section
Sec. 6	*January 1, 2026*	38a-501

Sec. 7	*January 1, 2026*	38a-528
Sec. 8	*January 1, 2026*	Repealer section

INS *Joint Favorable Subst.*

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 $
Revenue Serv., Dept.	GF - Revenue Loss	None	67.2 million
Revenue Serv., Dept.	GF - Cost	None	20,000
Insurance Dept.	IF - Cost	45,000-75,000	None

Note: IF=Insurance Fund; GF=General Fund

Municipal Impact: None

Explanation

The bill, which makes various changes to long-term care insurance (LTC) policy laws, establishes a LTC premium tax credit, and requires certain evaluations by the Insurance Department, results in (1) an ongoing General Fund revenue loss of $67.2 million beginning in FY 27, (2) a one-time Insurance Fund cost of $45,000 to $75,000 in FY 26 only, and (3) a one-time General Fund cost to the Department of Revenue Services (DRS) of $20,000 in FY 27 only.

LTC Tax Credit

Section 4 establishes a personal income tax credit of 20% of LTC insurance premiums paid for resident filers with federal adjusted gross income of less than $200,000. This results a (1) General Fund revenue loss of $67.2 million in FY 27 and (2) one-time cost of $20,000 to the (DRS) to implement tax form changes in FY 27 only.

Insurance Department Evaluations

Sections 1 and 5 require the Insurance Department to conduct two

evaluations by February 1, 2026: (1) an alternative pool for LTC policyholders; and (2) the department's individual and group LTC premium rate filing processes. The estimated costs are $30,000 to $50,000 and $15,000 to $25,000 for each evaluation, respectively. This results in a one-time cost of $45,000 to $75,000 to the Insurance Fund in FY 26 associated with hiring a contractor to complete the evaluations.

The Out Years

The revenue impact identified above would continue into the future subject to inflation in long-term care insurance premiums.

The cost impacts identified above are one-time in nature and do not result in a fiscal impact in the out years.

Sources: *AARP*
CTMirror "Policyholders Press CT Lawmakers for Long-Term Care Insurance Reform", 2/11/25

OLR Bill Analysis

sSB 1269

AN ACT CONCERNING LONG-TERM CARE INSURANCE.

SUMMARY

This bill makes various changes in laws related to long-term care (LTC) insurance policies (see BACKGROUND), specifically related to things such as LTC riders, individual and group LTC insurance premium rate increases, and tax credits for certain LTC policy premiums.

Regarding LTC riders, the bill specifically allows certain life insurance companies doing business in the state to issue LTC riders subject to requirements the bill establishes and state insurance statutes and regulations. Under the bill, an "LTC rider" is any provision or endorsement attached to an annuity contract or certificate that provides LTC benefits for qualified LTC services (see below).

Regarding individual and group LTC policy premium rate increases, the bill caps, at 10%, the premium rate increases that LTC insurers (i.e. insurers, fraternal benefit societies, hospital or medical service corporations, and HMOs) can request in their rate filings. However, regardless of this provision, the bill prohibits LTC insurers from filing a premium 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.

The bill repeals a provision it makes obsolete related to a minimum set of affordable benefit options that current law requires LTC insurers to offer in any individual or group LTC policy for which they have filed a 20% or higher premium rate increase.

Additionally, the bill generally allows an eligible taxpayer (see below) to get a credit against the state income tax in an amount equal to 20% of the LTC policy premiums he or she paid during the taxable year for which he or she is the insured.

It also requires the Insurance Department, by February 1, 2026, to report to the Insurance and Real Estate Committee an evaluation of (1) an alternative pool for LTC policyholders over 20 years and (2) the individual and group LTC premium rate filing processes as amended by the bill (§§ 1 & 5).

Lastly it makes minor, technical, and conforming changes.

EFFECTIVE DATE: January 1, 2026, except the (1) tax credit provision (§ 4) is applicable to taxable years beginning on or after January 1, 2026, and (2) Insurance Department reporting provisions (§§ 1 & 5) are effective upon passage.

§§ 2 & 3 — LONG-TERM CARE RIDERS

License and Approval Requirements

Under the bill, to be authorized to sell LTC riders in the state, a life insurance company must be doing business in the state and be licensed to issue both life and health insurance here.

As is the case under existing law for other riders, the bill requires LTC riders used in connection with a life insurance policy or annuity contract delivered or issued in the state to be filed with and approved by the insurance commissioner.

Disclosure Requirements

Any life insurance company that issues an LTC rider under the bill must disclose the following to each policyholder in writing:

1. the cost of the LTC rider and any impact it may have on the annuity contract's benefits, including reductions in death benefits or surrender value;
2. any conditions or LTC benefit triggers required by state or federal law, including qualifying events such as an inability to perform at least two activities of daily living or conditions related to severe cognitive impairment; and
3. any exclusions, limitations, or coordination of benefits with other

insurance coverage.

Other Requirements

The bill also requires life insurance companies that issue an LTC rider to:

1. comply with any applicable requirement under Connecticut insurance laws regarding annuity contract suitability, LTC insurance, and disclosure;
2. comply with any applicable requirements under federal law, including tax-qualified LTC policy requirements under HIPAA;
3. include nonforfeiture benefits required under Connecticut insurance statutes and applicable regulations;
4. only provide coverage for LTC rider benefits upon the occurrence of a qualifying event, as defined in the policy and required under Connecticut insurance statutes and regulations and federal law; and
5. allow a policyholder to cancel the LTC rider within 30 days after receiving it, without penalty.

Qualified LTC Services

Under the bill, "qualified LTC services" are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, as well as maintenance or personal care services, required by a chronically ill individual and prescribed by a licensed health care practitioner.

§§ 6 & 7 — PREMIUM RATE INCREASES OF LTC POLICIES

Under current law, any LTC insurer that requests a premium rate increase of 20% or more in its rate filing for an individual or group LTC policy must spread the increase over at least a three-year period and not file a rate filing for an increase during that period. Current law also requires the insurers to use a periodic rate increase that is actuarially equivalent to a single rate increase and a current interest rate during the

period.

The bill eliminates these requirements and instead caps, at 10%, the premium rate increase that LTC insurers can request in their LTC policy rate filings. However, regardless of this provision, for policyholders that have held their LTC policies for at least 15 years, the bill prohibits LTC insurers from filing a premium rate increase that exceeds the most recent calendar year average in the consumer price index for urban consumers.

§ 8 — AFFORDABLE BENEFIT OPTIONS REPEALED

Under current law, the insurance commissioner must develop and prescribe a minimum set of affordable benefit options to be offered by an LTC insurer that submits a rate filing for an individual or group LTC policy premium rate increase of 20% or more. The bill repeals this provision, which it makes obsolete, and eliminates related provisions in current law that require LTC insurers to disclose the availability of these affordable benefit options to policyholders.

§ 4 — TAX CREDIT FOR ELIGIBLE TAXPAYERS

The bill generally allows a resident of this state (see below) whose federal adjusted gross income is less than $200,000 ("eligible taxpayer") to get a credit against his or her state income tax, excluding any liability on payroll or nonpayroll taxes deducted and withheld, in an amount equal to 20% of the premiums paid by the eligible taxpayer during the taxable year for an LTC policy for which the eligible taxpayer is the insured. This tax credit is applicable to tax years starting on or after January 1, 2026.

Resident of This State

Under the bill, a "resident of the state" is any natural person (1) who is generally domiciled in this state or (2) who is not domiciled in this state but maintains a permanent residence in this state and is in this state for an aggregate of more than 183 days of the taxable year, unless the person is in active service in the U.S. armed forces (CGS § 12-701).

BACKGROUND

Long-Term Care Policy

By law, an "LTC policy" generally means any individual or group health insurance policy or certificate delivered or issued for delivery to a 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 certain elimination period (CGS §§ 38a-501 & -528).

Related Bills

SB 1278, favorably reported by the Aging Committee, creates a personal income tax deduction for LTC insurance premiums by allowing taxpayers to reduce their Connecticut adjusted gross income by the amount of any LTC insurance premiums they paid in the taxable year. It also 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.

sHB 7183, favorably reported by the Government Oversight Committee, (1) has provisions related to the evaluations and reports that this bill requires of the Insurance Department (§§ 1 & 5); (2) requires the Insurance Department to hold a hearing for any LTC policy premium rate increase above 10% and LTC insurers to give policyholders at least 14 days' notice of the hearing (§ 2); (3) requires LTC insurers to notify policyholders of the risk of future premium increases (§ 3); (4) indexes premium rate increases to the consumer price index for urban consumers for certain policies (§ 4); and (5) requires the state auditors to audit the Connecticut LTC Partnership (§ 6).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 12 Nay 1 (03/11/2025)