



General Assembly

January Session, 2021

Raised Bill No. 1041

LCO No. 3375



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***AN ACT CONCERNING HEALTH CARE SHARING PLANS AND
HEALTH CARE SHARING MINISTRIES.***

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

1 Section 1. Section 38a-1 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2021*):

3 Terms used in this title and sections 2 and 4 of this act, unless it
4 appears from the context to the contrary, shall have a scope and
5 meaning as set forth in this section.

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

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

12 (3) "Annuities" means all agreements to make periodical payments
13 where the making or continuance of all or some of the series of the

14 payments, or the amount of the payment, is dependent upon the
15 continuance of human life or is for a specified term of years. This
16 definition does not apply to payments made under a policy of life
17 insurance.

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

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

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

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

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

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

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
37 unable to pay its obligations when they are due, or when its admitted
38 assets do not exceed its liabilities plus the greater of: (A) Capital and
39 surplus required by law for its organization and continued operation;
40 or (B) the total par or stated value of its authorized and issued capital
41 stock. For purposes of this subdivision "liabilities" shall include but not
42 be limited to reserves required by statute or by regulations adopted by
43 the commissioner in accordance with the provisions of chapter 54 or

44 specific requirements imposed by the commissioner upon a subject
45 company at the time of admission or subsequent thereto.

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

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

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

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

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

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

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

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

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

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

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

92 Sec. 2. (NEW) (*Effective October 1, 2021*) (a) For the purposes of this
93 section, "health care sharing plan" means an arrangement of members
94 that encourages its members, or an affiliation or network of individuals
95 that encourages such individuals, to cover, in whole or in part, the
96 medical, health care, assisted living or prescription drug costs, or
97 wellness expenses, of other such members or individuals.

98 (b) Notwithstanding any provision of the general statutes, no person
99 shall receive a fee or anything of value in exchange for:

100 (1) Selling or soliciting a health care sharing plan for a resident of this
101 state;

102 (2) Negotiating a health care sharing plan on behalf of a resident of
103 this state; or

104 (3) Administering a health care sharing plan that includes a resident
105 of this state.

106 (c) Any violation of this section shall be deemed an unfair method of
107 competition and unfair and deceptive act or practice in the business of
108 insurance under section 38a-816 of the general statutes, as amended by
109 this act.

110 Sec. 3. Section 38a-816 of the general statutes is repealed and the
111 following is substituted in lieu thereof (*Effective October 1, 2021*):

112 The following are defined as unfair methods of competition and
113 unfair and deceptive acts or practices in the business of insurance:

114 (1) Misrepresentations and false advertising of insurance policies.
115 Making, issuing or circulating, or causing to be made, issued or
116 circulated, any estimate, illustration, circular or statement, sales
117 presentation, omission or comparison which: (A) Misrepresents the
118 benefits, advantages, conditions or terms of any insurance policy; (B)
119 misrepresents the dividends or share of the surplus to be received, on
120 any insurance policy; (C) makes any false or misleading statements as
121 to the dividends or share of surplus previously paid on any insurance
122 policy; (D) is misleading or is a misrepresentation as to the financial
123 condition of any person, or as to the legal reserve system upon which
124 any life insurer operates; (E) uses any name or title of any insurance
125 policy or class of insurance policies misrepresenting the true nature
126 thereof; (F) is a misrepresentation, including, but not limited to, an
127 intentional misquote of a premium rate, for the purpose of inducing or
128 tending to induce to the purchase, lapse, forfeiture, exchange,
129 conversion or surrender of any insurance policy; (G) is a
130 misrepresentation for the purpose of effecting a pledge or assignment of
131 or effecting a loan against any insurance policy; or (H) misrepresents
132 any insurance policy as being shares of stock.

133 (2) False information and advertising generally. Making, publishing,
134 disseminating, circulating or placing before the public, or causing,
135 directly or indirectly, to be made, published, disseminated, circulated or

136 placed before the public, in a newspaper, magazine or other publication,
137 or in the form of a notice, circular, pamphlet, letter or poster, or over any
138 radio or television station, or in any other way, an advertisement,
139 announcement or statement containing any assertion, representation or
140 statement with respect to the business of insurance or with respect to
141 any person in the conduct of his insurance business, which is untrue,
142 deceptive or misleading.

143 (3) Defamation. Making, publishing, disseminating or circulating,
144 directly or indirectly, or aiding, abetting or encouraging the making,
145 publishing, disseminating or circulating of, any oral or written
146 statement or any pamphlet, circular, article or literature which is false
147 or maliciously critical of or derogatory to the financial condition of an
148 insurer, and which is calculated to injure any person engaged in the
149 business of insurance.

150 (4) Boycott, coercion and intimidation. Entering into any agreement
151 to commit, or by any concerted action committing, any act of boycott,
152 coercion or intimidation resulting in or tending to result in unreasonable
153 restraint of, or monopoly in, the business of insurance.

154 (5) False financial statements. Filing with any supervisory or other
155 public official, or making, publishing, disseminating, circulating or
156 delivering to any person, or placing before the public, or causing,
157 directly or indirectly, to be made, published, disseminated, circulated or
158 delivered to any person, or placed before the public, any false statement
159 of financial condition of an insurer with intent to deceive; or making any
160 false entry in any book, report or statement of any insurer with intent to
161 deceive any agent or examiner lawfully appointed to examine into its
162 condition or into any of its affairs, or any public official to whom such
163 insurer is required by law to report, or who has authority by law to
164 examine into its condition or into any of its affairs, or, with like intent,
165 wilfully omitting to make a true entry of any material fact pertaining to
166 the business of such insurer in any book, report or statement of such
167 insurer.

168 (6) Unfair claim settlement practices. Committing or performing with
169 such frequency as to indicate a general business practice any of the
170 following: (A) Misrepresenting pertinent facts or insurance policy
171 provisions relating to coverages at issue; (B) failing to acknowledge and
172 act with reasonable promptness upon communications with respect to
173 claims arising under insurance policies; (C) failing to adopt and
174 implement reasonable standards for the prompt investigation of claims
175 arising under insurance policies; (D) refusing to pay claims without
176 conducting a reasonable investigation based upon all available
177 information; (E) failing to affirm or deny coverage of claims within a
178 reasonable time after proof of loss statements have been completed; (F)
179 not attempting in good faith to effectuate prompt, fair and equitable
180 settlements of claims in which liability has become reasonably clear; (G)
181 compelling insureds to institute litigation to recover amounts due under
182 an insurance policy by offering substantially less than the amounts
183 ultimately recovered in actions brought by such insureds; (H)
184 attempting to settle a claim for less than the amount to which a
185 reasonable man would have believed he was entitled by reference to
186 written or printed advertising material accompanying or made part of
187 an application; (I) attempting to settle claims on the basis of an
188 application which was altered without notice to, or knowledge or
189 consent of the insured; (J) making claims payments to insureds or
190 beneficiaries not accompanied by statements setting forth the coverage
191 under which the payments are being made; (K) making known to
192 insureds or claimants a policy of appealing from arbitration awards in
193 favor of insureds or claimants for the purpose of compelling them to
194 accept settlements or compromises less than the amount awarded in
195 arbitration; (L) delaying the investigation or payment of claims by
196 requiring an insured, claimant, or the physician of either to submit a
197 preliminary claim report and then requiring the subsequent submission
198 of formal proof of loss forms, both of which submissions contain
199 substantially the same information; (M) failing to promptly settle claims,
200 where liability has become reasonably clear, under one portion of the
201 insurance policy coverage in order to influence settlements under other
202 portions of the insurance policy coverage; (N) failing to promptly

203 provide a reasonable explanation of the basis in the insurance policy in
204 relation to the facts or applicable law for denial of a claim or for the offer
205 of a compromise settlement; (O) using as a basis for cash settlement with
206 a first party automobile insurance claimant an amount which is less than
207 the amount which the insurer would pay if repairs were made unless
208 such amount is agreed to by the insured or provided for by the
209 insurance policy.

210 (7) Failure to maintain complaint handling procedures. Failure of any
211 person to maintain complete record of all the complaints which it has
212 received since the date of its last examination. This record shall indicate
213 the total number of complaints, their classification by line of insurance,
214 the nature of each complaint, the disposition of these complaints, and
215 the time it took to process each complaint. For purposes of this
216 [subsection] subdivision, "complaint" means any written
217 communication primarily expressing a grievance.

218 (8) Misrepresentation in insurance applications. Making false or
219 fraudulent statements or representations on or relative to an application
220 for an insurance policy for the purpose of obtaining a fee, commission,
221 money or other benefit from any insurer, producer or individual.

222 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-
223 488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following
224 practices shall be considered discrimination within the meaning of
225 section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-
226 825: (A) Paying bonuses to policyholders or otherwise abating their
227 premiums in whole or in part out of surplus accumulated from
228 nonparticipating insurance, provided any such bonuses or abatement of
229 premiums shall be fair and equitable to policyholders and for the best
230 interests of the company and its policyholders; (B) in the case of policies
231 issued on the industrial debit plan, making allowance to policyholders
232 who have continuously for a specified period made premium payments
233 directly to an office of the insurer in an amount which fairly represents
234 the saving in collection expense; (C) readjustment of the rate of premium
235 for a group insurance policy based on loss or expense experience, or

236 both, at the end of the first or any subsequent policy year, which may be
237 made retroactive for such policy year.

238 (10) Notwithstanding any provision of any policy of insurance,
239 certificate or service contract, whenever such insurance policy or
240 certificate or service contract provides for reimbursement for any
241 services which may be legally performed by any practitioner of the
242 healing arts licensed to practice in this state, reimbursement under such
243 insurance policy, certificate or service contract shall not be denied
244 because of race, color or creed nor shall any insurer make or permit any
245 unfair discrimination against particular individuals or persons so
246 licensed.

247 (11) Favored agent or insurer: Coercion of debtors. (A) No person
248 may (i) require, as a condition precedent to the lending of money or
249 extension of credit, or any renewal thereof, that the person to whom
250 such money or credit is extended or whose obligation the creditor is to
251 acquire or finance, negotiate any policy or contract of insurance through
252 a particular insurer or group of insurers or producer or group of
253 producers; (ii) unreasonably disapprove the insurance policy provided
254 by a borrower for the protection of the property securing the credit or
255 lien; (iii) require directly or indirectly that any borrower, mortgagor,
256 purchaser, insurer or producer pay a separate charge, in connection
257 with the handling of any insurance policy required as security for a loan
258 on real estate or pay a separate charge to substitute the insurance policy
259 of one insurer for that of another; or (iv) use or disclose information
260 resulting from a requirement that a borrower, mortgagor or purchaser
261 furnish insurance of any kind on real property being conveyed or used
262 as collateral security to a loan, when such information is to the
263 advantage of the mortgagee, vendor or lender, or is to the detriment of
264 the borrower, mortgagor, purchaser, insurer or the producer complying
265 with such a requirement.

266 (B) (i) Subparagraph (A)(iii) of this subdivision shall not include the
267 interest which may be charged on premium loans or premium
268 advancements in accordance with the security instrument. (ii) For

269 purposes of subparagraph (A)(ii) of this subdivision, such disapproval
270 shall be deemed unreasonable if it is not based solely on reasonable
271 standards uniformly applied, relating to the extent of coverage required
272 and the financial soundness and the services of an insurer. Such
273 standards shall not discriminate against any particular type of insurer,
274 nor shall such standards call for the disapproval of an insurance policy
275 because such policy contains coverage in addition to that required. (iii)
276 The commissioner may investigate the affairs of any person to whom
277 this subdivision applies to determine whether such person has violated
278 this subdivision. If a violation of this subdivision is found, the person in
279 violation shall be subject to the same procedures and penalties as are
280 applicable to other provisions of section 38a-815, subsections (b) and (e)
281 of section 38a-817 and this section. (iv) For purposes of this section,
282 "person" includes any individual, corporation, limited liability
283 company, association, partnership or other legal entity.

284 (12) Refusing to insure, refusing to continue to insure or limiting the
285 amount, extent or kind of coverage available to an individual or
286 charging an individual a different rate for the same coverage because of
287 physical disability, mental or nervous condition as set forth in section
288 38a-488a or intellectual disability, except where the refusal, limitation or
289 rate differential is based on sound actuarial principles or is related to
290 actual or reasonably anticipated experience.

291 (13) Refusing to insure, refusing to continue to insure or limiting the
292 amount, extent or kind of coverage available to an individual or
293 charging an individual a different rate for the same coverage solely
294 because of blindness or partial blindness. For purposes of this
295 subdivision, "refusal to insure" includes the denial by an insurer of
296 disability insurance coverage on the grounds that the policy defines
297 "disability" as being presumed in the event that the insured is blind or
298 partially blind, except that an insurer may exclude from coverage any
299 disability, consisting solely of blindness or partial blindness, when such
300 condition existed at the time the policy was issued. Any individual who
301 is blind or partially blind shall be subject to the same standards of sound
302 actuarial principles or actual or reasonably anticipated experience as are

303 sighted persons with respect to all other conditions, including the
304 underlying cause of the blindness or partial blindness.

305 (14) Refusing to insure, refusing to continue to insure or limiting the
306 amount, extent or kind of coverage available to an individual or
307 charging an individual a different rate for the same coverage because of
308 exposure to diethylstilbestrol through the female parent.

309 (15) (A) Failure by an insurer, or any other entity responsible for
310 providing payment to a health care provider pursuant to an insurance
311 policy, to pay accident and health claims, including, but not limited to,
312 claims for payment or reimbursement to health care providers, within
313 the time periods set forth in subparagraph (B) of this subdivision, unless
314 the Insurance Commissioner determines that a legitimate dispute exists
315 as to coverage, liability or damages or that the claimant has fraudulently
316 caused or contributed to the loss. Any insurer, or any other entity
317 responsible for providing payment to a health care provider pursuant
318 to an insurance policy, who fails to pay such a claim or request within
319 the time periods set forth in subparagraph (B) of this subdivision shall
320 pay the claimant or health care provider the amount of such claim plus
321 interest at the rate of fifteen per cent per annum, in addition to any other
322 penalties which may be imposed pursuant to sections 38a-11, 38a-25,
323 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64,
324 inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129
325 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to
326 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
327 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
328 inclusive. Whenever the interest due a claimant or health care provider
329 pursuant to this section is less than one dollar, the insurer shall deposit
330 such amount in a separate interest-bearing account in which all such
331 amounts shall be deposited. At the end of each calendar year each such
332 insurer shall donate such amount to The University of Connecticut
333 Health Center.

334 (B) Each insurer or other entity responsible for providing payment to
335 a health care provider pursuant to an insurance policy subject to this

336 section, shall pay claims not later than:

337 (i) For claims filed in paper format, sixty days after receipt by the
338 insurer of the claimant's proof of loss form or the health care provider's
339 request for payment filed in accordance with the insurer's practices or
340 procedures, except that when there is a deficiency in the information
341 needed for processing a claim, as determined in accordance with section
342 38a-477, the insurer shall (I) send written notice to the claimant or health
343 care provider, as the case may be, of all alleged deficiencies in
344 information needed for processing a claim not later than thirty days
345 after the insurer receives a claim for payment or reimbursement under
346 the contract, and (II) pay claims for payment or reimbursement under
347 the contract not later than thirty days after the insurer receives the
348 information requested; and

349 (ii) For claims filed in electronic format, twenty days after receipt by
350 the insurer of the claimant's proof of loss form or the health care
351 provider's request for payment filed in accordance with the insurer's
352 practices or procedures, except that when there is a deficiency in the
353 information needed for processing a claim, as determined in accordance
354 with section 38a-477, the insurer shall (I) notify the claimant or health
355 care provider, as the case may be, of all alleged deficiencies in
356 information needed for processing a claim not later than ten days after
357 the insurer receives a claim for payment or reimbursement under the
358 contract, and (II) pay claims for payment or reimbursement under the
359 contract not later than ten days after the insurer receives the information
360 requested.

361 (C) As used in this subdivision, "health care provider" means a person
362 licensed to provide health care services under chapter 368d, chapter
363 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c,
364 inclusive, or chapter 400j.

365 (16) Failure to pay, as part of any claim for a damaged motor vehicle
366 under any automobile insurance policy where the vehicle has been
367 declared to be a constructive total loss, an amount equal to the sum of

368 (A) the settlement amount on such vehicle plus, whenever the insurer
369 takes title to such vehicle, (B) an amount determined by multiplying
370 such settlement amount by a percentage equivalent to the current sales
371 tax rate established in section 12-408. For purposes of this subdivision,
372 "constructive total loss" means the cost to repair or salvage damaged
373 property, or the cost to both repair and salvage such property, equals or
374 exceeds the total value of the property at the time of the loss.

375 (17) Any violation of section 42-260, by an extended warranty
376 provider subject to the provisions of said section, including, but not
377 limited to: (A) Failure to include all statements required in subsections
378 (c) and (f) of section 42-260 in an issued extended warranty; (B) offering
379 an extended warranty without being (i) insured under an adequate
380 extended warranty reimbursement insurance policy or (ii) able to
381 demonstrate that reserves for claims contained in the provider's
382 financial statements are not in excess of one-half the provider's audited
383 net worth; (C) failure to submit a copy of an issued extended warranty
384 form or a copy of such provider's extended warranty reimbursement
385 policy form to the Insurance Commissioner.

386 (18) With respect to an insurance company, hospital service
387 corporation, health care center or fraternal benefit society providing
388 individual or group health insurance coverage of the types specified in
389 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469,
390 refusing to insure, refusing to continue to insure or limiting the amount,
391 extent or kind of coverage available to an individual or charging an
392 individual a different rate for the same coverage because such
393 individual has been a victim of family violence.

394 (19) With respect to an insurance company, hospital service
395 corporation, health care center or fraternal benefit society providing
396 individual or group health insurance coverage of the types specified in
397 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469,
398 refusing to insure, refusing to continue to insure or limiting the amount,
399 extent or kind of coverage available to an individual or charging an
400 individual a different rate for the same coverage because of genetic

401 information. Genetic information indicating a predisposition to a
402 disease or condition shall not be deemed a preexisting condition in the
403 absence of a diagnosis of such disease or condition that is based on other
404 medical information. An insurance company, hospital service
405 corporation, health care center or fraternal benefit society providing
406 individual health coverage of the types specified in subdivisions (1), (2),
407 (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be
408 prohibited from refusing to insure or applying a preexisting condition
409 limitation, to the extent permitted by law, to an individual who has been
410 diagnosed with a disease or condition based on medical information
411 other than genetic information and has exhibited symptoms of such
412 disease or condition. For the purposes of this [subsection] subdivision,
413 "genetic information" means the information about genes, gene
414 products or inherited characteristics that may derive from an individual
415 or family member.

416 (20) Any violation of sections 38a-465 to 38a-465q, inclusive.

417 (21) With respect to a managed care organization, as defined in
418 section 38a-478, failing to establish a confidentiality procedure for
419 medical record information, as required by section 38a-999.

420 (22) Any violation of sections 38a-591d to 38a-591f, inclusive.

421 (23) Any violation of section 38a-472j.

422 (24) Any violation of section 2 of this act.

423 Sec. 4. (NEW) (*Effective October 1, 2021*) (a) For the purposes of this
424 section:

425 (1) "Health care sharing ministry" means any person that (A) is not a
426 health carrier, (B) uses the phrase health care sharing ministry, health
427 sharing ministry or any similar phrase to refer to itself, and (C) holds
428 itself out as offering a means of, or alternative to, maintaining minimum
429 essential coverage;

430 (2) "Health care sharing plan" has the same meaning as provided in

431 section 2 of this act;

432 (3) "Health carrier" has the same meaning as provided in section 38a-
433 1080 of the general statutes; and

434 (4) "Minimum essential coverage" has the same meaning as provided
435 in Section 5000A of the Internal Revenue Code of 1986.

436 (b) Notwithstanding any provision of the general statutes, no person
437 licensed by the department shall conduct any business with, or conduct
438 any act requiring a license issued by the department on behalf of, a
439 health care sharing ministry or health care sharing plan. The provisions
440 of this subsection shall remain effective regardless of whether the
441 requirement that an individual maintain minimum essential coverage,
442 or any provision of the Patient Protection and Affordable Care Act, P.L.
443 111-148, is repealed or rendered ineffective by operation of law.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2021</i>	38a-1
Sec. 2	<i>October 1, 2021</i>	New section
Sec. 3	<i>October 1, 2021</i>	38a-816
Sec. 4	<i>October 1, 2021</i>	New section

Statement of Purpose:

To provide that: (1) No person shall receive a fee or anything of value in exchange for (A) selling or soliciting a health care sharing plan for a resident of this state, (B) negotiating a health care sharing plan on behalf of a resident of this state, or (C) administering a health care sharing plan that includes a resident of this state; (2) certain prohibited transactions with, or on behalf of, health care sharing plans violate the Connecticut Unfair Insurance Practices Act; and (3) no person licensed by the Insurance Department shall conduct any business with, or conduct any act requiring a license issued by the department on behalf of, a health care sharing ministry or health care sharing plan.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]