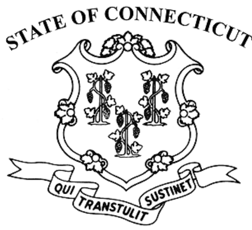

House of Representatives

General Assembly

File No. 330

January Session, 2023

Substitute House Bill No. 6710

House of Representatives, March 30, 2023

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING ASSOCIATION HEALTH PLANS AND ESTABLISHING A TASK FORCE TO STUDY STOP-LOSS INSURANCE.

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

1 Section 1. (NEW) (*Effective October 1, 2023*) For the purposes of this
2 section and sections 2, 3 and 5 of this act:

3 (1) "Commissioner" means the Insurance Commissioner;

4 (2) "Employer member" means an entity in this state that is part of a
5 sponsoring association, conducts business in this state and employs
6 individuals in this state;

7 (3) "ERISA" means the Employee Retirement Income Security Act of
8 1974, as amended from time to time;

9 (4) "Fully insured multiple employer welfare arrangement" means
10 any health benefit plan offered by a sponsoring association for the
11 purpose of providing insurance to participating employees of a

12 sponsoring association that is funded through a policy of insurance
13 issued by a licensed insurance company in this state;

14 (5) "Health enhancement program" means any health benefit
15 program that ensures access and removes barriers to essential, high-
16 value clinical services;

17 (6) "Preexisting conditions provision" has the same meaning as
18 provided in section 38a-476 of the general statutes;

19 (7) "Self-funded multiple employer welfare arrangement" means any
20 health benefit plan offered by a sponsoring association, that is not fully
21 insured by a licensed insurance company in this state, for the purpose
22 of providing insurance to participating employer members of a
23 sponsoring association;

24 (8) "Sponsoring association" means any industry trade group or any
25 other trade group with employer members representing multiple trades
26 incorporated in this state that (A) is organized and has a written
27 constitution or bylaws, (B) has not less than fifty employer members,
28 and (C) has been maintained in good faith for not less than the
29 immediately preceding five years for purposes other than obtaining or
30 providing insurance; and

31 (9) "Value-based insurance design" means any material term in a
32 health insurance policy that is designed to increase the quality of
33 covered benefits or health care services while reducing the cost of such
34 policy, benefits or health care services.

35 Sec. 2. (NEW) (*Effective October 1, 2023*) (a) No self-funded multiple
36 employer welfare arrangement shall issue any health benefit plan in this
37 state unless such self-funded multiple employer welfare arrangement
38 first obtains a license from the commissioner.

39 (b) Any health benefit plan issued by a self-funded multiple
40 employer welfare arrangement that covers one or more employees of
41 one or more participating employer members of a sponsoring
42 association shall:

43 (1) Provide coverage for (A) essential health benefits as defined in the
44 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
45 from time to time, or regulations adopted thereunder, and (B) the state
46 mandated coverage requirements under chapter 700c of the general
47 statutes;

48 (2) Offer a minimum level of coverage designed to provide health
49 benefits that are actuarially equivalent to not less than sixty per cent of
50 the full actuarial value of the benefits provided under the health benefit
51 plan and include coverage for inpatient hospital services and physician
52 services;

53 (3) Not limit or exclude coverage for any individual by imposing any
54 preexisting conditions provision on such individual;

55 (4) Not establish discriminatory rules based on the health status of an
56 individual related to health benefit plan eligibility, or premium or
57 contribution requirements;

58 (5) Establish base rates formed on an actuarially sound, modified
59 community rating methodology that considers the pooling of all
60 participants' claims;

61 (6) Utilize each employer member's risk profile to determine
62 premiums by actuarially adjusting above or below established base
63 rates, and utilize pooling or reinsurance of individual large claimants to
64 reduce the adverse impact on any specific employer member's
65 premiums;

66 (7) Make any health benefit plan available to all employer members
67 of a sponsoring association regardless of any factor relating to the health
68 status of such employer members or individuals eligible for coverage
69 through any employer member;

70 (8) Implement value-based insurance design and value-based
71 contracting by administering programs, which may include, but are not
72 limited to, centers of excellence, wellness programs, health
73 enhancement programs, alternative payment models, chronic disease

74 navigation, patient-centered medical homes and advanced primary
75 care; and

76 (9) Comply with the notification requirements to covered persons set
77 forth in sections 38a-591d, 38a-591e and 38a-591f of the general statutes
78 with respect to utilization review and benefit determinations of a benefit
79 request or claim.

80 (c) Any sponsoring association shall form a trust that shall establish
81 and maintain any health benefit plans for such sponsoring association.
82 Such trust shall be authorized to sell health benefit plans to employer
83 members of the sponsoring association by meeting the following
84 conditions:

85 (1) The trust shall be subject to ERISA and any regulations or
86 standards prescribed by the United States Department of Labor to
87 enforce multiple employer welfare arrangements;

88 (2) A Form M-1 shall be filed each year with the United States
89 Department of Labor. For purposes of this subdivision, "Form M-1"
90 means an annual report required by the United States Department of
91 Labor for multiple employer welfare arrangements that includes, but is
92 not limited to, the following: (A) Identification of the sponsoring
93 association and trust establishing a self-funded multiple employer
94 welfare arrangement; and (B) a description of any health benefit plans
95 offered through the trust as a self-funded multiple employer welfare
96 arrangement;

97 (3) Any organizational documents for a trust shall:

98 (A) State that such trust is sponsored by the sponsoring association;

99 (B) State that the purpose of such trust is to provide health care
100 benefits, including, but not limited to, medical, prescription drug, dental
101 and vision benefits, to participating employees of the sponsoring
102 association or its members, and the dependents of such participating
103 employees or members, through health benefit plans;

104 (C) Provide that trust funds shall be used for the benefit of
105 participating employees of the sponsoring association and the
106 dependents of such participating employees, through (i) self-funding of
107 claims or the purchase of reinsurance, or any combination thereof, and
108 (ii) defraying the costs and expenses of administering and operating
109 such trust and any health benefit plan;

110 (D) Limit participation in any health benefit plan to participating
111 employees of the sponsoring association and such sponsoring
112 association's employer members;

113 (E) Establish and maintain a board of trustees, composed of not less
114 than five trustees, that shall have fiscal control over such self-funded
115 multiple employer welfare arrangement. Any board of trustees shall
116 have the authority to (i) approve applications of association employer
117 members for participation in the self-funded multiple employer welfare
118 arrangement, and (ii) contract with any licensed administrator or service
119 company to administer the daily operations of the self-funded multiple
120 employer welfare arrangement;

121 (F) Implement a process for the election of trustees to the board of
122 trustees; and

123 (G) Require each trustee to discharge such trustee's duties in
124 accordance with generally accepted fiduciary standards, as determined
125 by the commissioner, in accordance with the provisions of chapter 54 of
126 the general statutes;

127 (4) The trust shall establish and maintain reserves calculated in
128 accordance with the accounting requirements of the National
129 Association of Insurance Commissioners Accounting Practices and
130 Procedures Manual, version effective January 1, 2001, and subsequent
131 revisions, and in accordance with any financial and solvency
132 regulations adopted by the commissioner, in accordance with the
133 provisions of chapter 54 of the general statutes;

134 (5) The trust shall purchase and maintain an insurance policy

135 providing coverage for stop-loss insurance with retention levels
136 determined in accordance with actuarial principles from insurers
137 licensed to transact the business of insurance in this state;

138 (6) The trust shall purchase and maintain commercially reasonable
139 fiduciary liability insurance from insurers licensed to transact the
140 business of insurance in this state;

141 (7) The trust shall purchase and maintain a bond in an amount and
142 form approved by the commissioner; and

143 (8) No trust shall include in its name, the words "insurance",
144 "insurer", "underwriter", "mutual", or any other word or term or
145 combination of words or terms that is descriptive of an insurance
146 company or insurance business, unless the context of such words or
147 terms indicate that such trust is not an insurance company and is not
148 transacting the business of insurance.

149 (d) Any board of trustees established pursuant to subsection (c) of
150 this section shall:

151 (1) Operate any health benefit plans in accordance with generally
152 accepted fiduciary standards, as established in regulations adopted by
153 the commissioner, in accordance with the provisions of chapter 54 of the
154 general statutes; and

155 (2) Have the authority to collect special assessments against employer
156 members and enforce the collection of such special assessments.

157 (e) Each employer member shall be liable for such employer
158 member's allocated share of the liabilities of the sponsoring association
159 under any health benefit plan, as determined by the board of trustees.

160 (f) Health benefit plan documents issued by any such self-funded
161 multiple employer welfare arrangement shall have the following
162 statement printed on the first page in fourteen-point boldface type: "This
163 coverage is not insurance and is not offered through an insurance
164 company. This coverage is not required to comply with certain federal

165 market requirements for health insurance, and is not required to comply
166 with certain state laws for health insurance. Each employer member
167 shall be liable for such employer member's allocated share of the
168 liabilities of the sponsoring association under the health benefit plans as
169 determined by the board of trustees. Each employer member may be
170 responsible for paying an additional sum if the annual premiums
171 present a deficit of funds for the trust. The trust's financial documents
172 shall be made available upon request by a participant in the health
173 benefit plan".

174 (g) This section shall not apply to any fully insured multiple
175 employer welfare arrangement that offers or provides any health benefit
176 plan that is fully insured by any insurer authorized to transact the
177 business of insurance in this state.

178 (h) The commissioner shall adopt regulations, in accordance with the
179 provisions of chapter 54 of the general statutes, to implement the
180 provisions of this section, including, but not limited to, the requirements
181 of self-funded multiple employer welfare arrangements for: (1)
182 Licensing; (2) financial condition and actuarial standards; (3) solvency
183 and insolvency, including, but not limited to, the use of trust deposits
184 and security bonds; (4) transparency and reporting; and (5) filings.

185 Sec. 3. (NEW) (*Effective October 1, 2023*) (a) Any sponsoring
186 association that sponsors any fully insured multiple employer welfare
187 arrangement shall have a written constitution and bylaws that require:

188 (1) The sponsoring association to hold regular meetings not less than
189 once annually to further the purposes of such sponsoring association's
190 participating employers; and

191 (2) The sponsoring association to collect dues or solicit contributions
192 from such sponsoring association's participating employers.

193 (b) Any health benefit plan issued by any fully insured multiple
194 employer welfare arrangement shall:

195 (1) Comply with regulations or standards prescribed by the United

196 States Department of Labor pertaining to multiple employer welfare
197 arrangements;

198 (2) Qualify as a large group market plan subject to (A) all coverage
199 mandates under chapter 700c of the general statutes applicable to a large
200 group market plan offered in this state, and (B) the large group market
201 insurance regulations pursuant to the Public Health Service Act, 42 USC
202 2791, as amended from time to time;

203 (3) Adhere to the group health plan coverage requirements under the
204 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
205 from time to time;

206 (4) Not limit or exclude coverage for any individual by imposing any
207 preexisting conditions provision on such individual;

208 (5) Provide coverage for (A) essential health benefits as defined in the
209 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
210 from time to time, or regulations adopted thereunder, and (B) the state
211 mandated coverage requirements under chapter 700c of the general
212 statutes;

213 (6) Offer a minimum level of coverage designed to provide benefits
214 that are actuarially equivalent to not less than sixty per cent of the full
215 actuarial value of the benefits provided under the health benefit plan;
216 and

217 (7) Be available only to participating employers of the fully insured
218 multiple employer welfare arrangement.

219 Sec. 4. Section 38a-567 of the general statutes is repealed and the
220 following is substituted in lieu thereof (*Effective October 1, 2023*):

221 Health insurance plans **[**, associations of small employers**]** and other
222 insurance arrangements covering small employers and insurers and
223 producers marketing such plans and arrangements shall be subject to
224 the following provisions:

225 (1) (A) Any such plan or arrangement shall be offered on a
226 guaranteed issue basis with respect to all eligible employees or
227 dependents of such employees, at the option of the small employer,
228 policyholder or contractholder, as the case may be.

229 (B) Any such plan or arrangement shall be renewable with respect to
230 all eligible employees or dependents at the option of the small employer,
231 policyholder or contractholder, as the case may be, except: (i) For
232 nonpayment of the required premiums by the small employer,
233 policyholder or contractholder; (ii) for fraud or misrepresentation of the
234 small employer, policyholder or contractholder or, with respect to
235 coverage of individual insured, the insureds or their representatives;
236 (iii) for noncompliance with plan or arrangement provisions; (iv) when
237 the number of insureds covered under the plan or arrangement is less
238 than the number of insureds or percentage of insureds required by
239 participation requirements under the plan or arrangement; or (v) when
240 the small employer, policyholder or contractholder is no longer actively
241 engaged in the business in which it was engaged on the effective date of
242 the plan or arrangement.

243 (C) Renewability of coverage may be effected by either continuing in
244 effect a plan or arrangement covering a small employer or by
245 substituting upon renewal for the prior plan or arrangement the plan or
246 arrangement then offered by the carrier that most closely corresponds
247 to the prior plan or arrangement and is available to other small
248 employers. Such substitution shall only be made under conditions
249 approved by the commissioner. A carrier may substitute a plan or
250 arrangement as set forth in this subparagraph only if the carrier effects
251 the same substitution upon renewal for all small employers previously
252 covered under the particular plan or arrangement, unless otherwise
253 approved by the commissioner. The substitute plan or arrangement
254 shall be subject to the rating restrictions specified in this section on the
255 same basis as if no substitution had occurred, except for an adjustment
256 based on coverage differences.

257 (D) Any such plan or arrangement shall provide special enrollment

258 periods (i) to all eligible employees or dependents as set forth in 45 CFR
259 147.104, as amended from time to time, and (ii) for coverage under such
260 plan or arrangement ordered by a court for a spouse or minor child of
261 an eligible employee where request for enrollment is made not later than
262 thirty days after the issuance of such court order.

263 (2) (A) As used in this subdivision, "grandfathered plan" has the same
264 meaning as "grandfathered health plan" as provided in the Patient
265 Protection and Affordable Care Act, P.L. 111-148, as amended from time
266 to time.

267 (B) With respect to grandfathered plans issued to small employers,
268 the premium rates charged or offered shall be established on the basis
269 of a single pool of all grandfathered plans, adjusted to reflect one or
270 more of the following classifications:

271 (i) Age, provided age brackets of less than five years shall not be
272 utilized;

273 (ii) Gender;

274 (iii) Geographic area, provided an area smaller than a county shall
275 not be utilized;

276 (iv) Industry, provided the rate factor associated with any industry
277 classification shall not vary from the arithmetic average of the highest
278 and lowest rate factors associated with all industry classifications by
279 greater than fifteen per cent of such average, and provided further, the
280 rate factors associated with any industry shall not be increased by more
281 than five per cent per year;

282 (v) Group size, provided the highest rate factor associated with group
283 size shall not vary from the lowest rate factor associated with group size
284 by a ratio of greater than 1.25 to 1.0;

285 (vi) Administrative cost savings resulting from the administration of
286 an association group plan or a plan written pursuant to section 5-259,
287 provided the savings reflect a reduction to the small employer carrier's

288 overall retention that is measurable and specifically realized on items
289 such as marketing, billing or claims paying functions taken on directly
290 by the plan administrator or association, except that such savings may
291 not reflect a reduction realized on commissions;

292 (vii) Savings resulting from a reduction in the profit of a carrier that
293 writes small business plans or arrangements for an association group
294 plan or a plan written pursuant to section 5-259, provided any loss in
295 overall revenue due to a reduction in profit is not shifted to other small
296 employers; and

297 (viii) Family composition, provided the small employer carrier shall
298 utilize only one or more of the following billing classifications: (I)
299 Employee; (II) employee plus family; (III) employee and spouse; (IV)
300 employee and child; (V) employee plus one dependent; and (VI)
301 employee plus two or more dependents.

302 (C) (i) With respect to nongrandfathered plans issued to small
303 employers, the premium rates charged or offered shall be established on
304 the basis of a single pool of all nongrandfathered plans, adjusted to
305 reflect one or more of the following classifications:

306 (I) Age, in accordance with a uniform age rating curve established by
307 the commissioner; or

308 (II) Geographic area, as defined by the commissioner.

309 (ii) Total premium rates for family coverage for nongrandfathered
310 plans shall be determined by adding the premiums for each individual
311 family member, except that with respect to family members under
312 twenty-one years of age, the premiums for only the three oldest covered
313 children shall be taken into account in determining the total premium
314 rate for such family.

315 (iii) Premium rates for employees and dependents for
316 nongrandfathered plans shall be calculated for each covered individual
317 and premium rates for the small employer group shall be calculated by
318 totaling the premiums attributable to each covered individual.

319 (iv) Premium rates for any given plan may vary by (I) actuarially
320 justified differences in plan design, and (II) actuarially justified amounts
321 to reflect the policy's provider network and administrative expense
322 differences that can be reasonably allocated to such policy.

323 (3) No small employer carrier or producer shall, directly or indirectly,
324 engage in the following activities:

325 (A) Encouraging or directing small employers to refrain from filing
326 an application for coverage with the small employer carrier because of
327 the health status, claims experience, industry, occupation or geographic
328 location of the small employer, except the provisions of this
329 subparagraph shall not apply to information provided by a small
330 employer carrier or producer to a small employer regarding the carrier's
331 established geographic service area or a restricted network provision of
332 a small employer carrier; or

333 (B) Encouraging or directing small employers to seek coverage from
334 another carrier because of the health status, claims experience, industry,
335 occupation or geographic location of the small employer.

336 (4) No small employer carrier shall, directly or indirectly, enter into
337 any contract, agreement or arrangement with a producer that provides
338 for or results in the compensation paid to a producer for the sale of a
339 health benefit plan to be varied because of the health status, claims
340 experience, industry, occupation or geographic area of the small
341 employer. A small employer carrier shall provide reasonable
342 compensation, as provided under the plan of operation of the program,
343 to a producer, if any, for the sale of a health care plan. No small
344 employer carrier shall terminate, fail to renew or limit its contract or
345 agreement of representation with a producer for any reason related to
346 the health status, claims experience, occupation, or geographic location
347 of the small employers placed by the producer with the small employer
348 carrier.

349 (5) No small employer carrier or producer shall induce or otherwise
350 encourage a small employer to separate or otherwise exclude an

351 employee from health coverage or benefits provided in connection with
352 the employee's employment.

353 (6) No small employer carrier or producer shall disclose (A) to a small
354 employer the fact that any or all of the eligible employees of such small
355 employer have been or will be reinsured with the pool, or (B) to any
356 eligible employee or dependent the fact that he has been or will be
357 reinsured with the pool.

358 (7) If a small employer carrier enters into a contract, agreement or
359 other arrangement with another party to provide administrative,
360 marketing or other services related to the offering of health benefit plans
361 to small employers in this state, the other party shall be subject to the
362 provisions of this section.

363 (8) The commissioner may adopt regulations, in accordance with the
364 provisions of chapter 54, setting forth additional standards to provide
365 for the fair marketing and broad availability of health benefit plans to
366 small employers.

367 (9) Any violation of subdivisions (3) to (7), inclusive, of this section
368 and of any regulations established under subdivision (8) of this section
369 shall be an unfair and prohibited practice under sections 38a-815 to 38a-
370 830, inclusive.

371 Sec. 5. (*Effective from passage*) (a) For the purposes of this section:

372 (1) "Stop-loss insurance plan" means any insurance policy purchased
373 by any employer, insurer, multiple employer welfare arrangement or
374 other provider of fully insured or self-funded small group health
375 coverage in this state that limits the financial risk of medical costs for
376 such employer, insurer, multiple employer welfare arrangement or
377 other provider of fully insured or self-funded small group health
378 coverage; and

379 (2) "Small group" means any employer or other purchaser of a stop-
380 loss insurance plan with not more than one hundred employees or
381 members.

382 (b) There is established a task force to study the structure of stop-loss
383 insurance plans and any impact that such plans may have on (1) small
384 groups and such groups' enrollees, and (2) medical spending in this
385 state.

386 (c) The task force shall make recommendations concerning: (1)
387 Measures to ensure access to affordable health care services to
388 purchasers of stop-loss insurance plans and such purchasers' enrollees
389 in health coverage utilizing stop-loss insurance plans; (2) any financial
390 impact that stop-loss insurance plans may have on (A) small groups in
391 this state, (B) enrollees and such enrollees' family members, and (C) the
392 fully insured health insurance market in this state; (3) the appropriate
393 role of stop-loss insurance plans in this state; and (4) consumer
394 protections for small groups, such small groups' enrollees and such
395 enrollees' family members covered by stop-loss insurance plans in this
396 state.

397 (d) The task force shall consist of the following members:

398 (1) Two appointed by the speaker of the House of Representatives,
399 one of whom shall be a representative of a small group in this state
400 utilizing a stop-loss insurance plan, and one of whom shall be a
401 representative of a small group in this state offering health coverage that
402 does not utilize a stop-loss insurance plan;

403 (2) Two appointed by the president pro tempore of the Senate, one of
404 whom shall have experience in managing employee benefits and be
405 knowledgeable with respect to stop-loss insurance in this state, and one
406 of whom shall be an insurance producer licensed in this state and be
407 knowledgeable with respect to stop-loss insurance in this state;

408 (3) One appointed by the majority leader of the House of
409 Representatives, who shall be a physician licensed pursuant to chapter
410 370 of the general statutes;

411 (4) One appointed by the majority leader of the Senate, who shall be
412 a representative of an advocacy organization focused on health equity;

413 (5) One appointed by the minority leader of the House of
414 Representatives, who shall be a representative of the Connecticut
415 Association of Health Plans;

416 (6) One appointed by the minority leader of the Senate, who shall be
417 a representative of the Connecticut Business and Industry Association;

418 (7) The Healthcare Advocate, or the Healthcare Advocate's designee;
419 and

420 (8) Three persons appointed by the Governor, one of whom shall be
421 a representative of a labor organization, one of whom shall be a
422 representative of an insurance carrier licensed to issue stop-loss
423 insurance plans in this state and one of whom shall be a representative
424 of a consumer advocacy organization.

425 (e) All initial appointments to the task force shall be made not later
426 than thirty days after the effective date of this section. Any vacancy shall
427 be filled by the appointing authority.

428 (f) The members of the task force shall select one or two chairpersons
429 of the task force from among the members of the task force. Such
430 chairperson or chairpersons shall schedule the first meeting of the task
431 force, which shall be held not later than sixty days after the effective date
432 of this section.

433 (g) The administrative staff of the joint standing committee of the
434 General Assembly having cognizance of matters relating to insurance
435 shall serve as administrative staff of the task force.

436 (h) Not later than February 1, 2024, the task force shall submit a report
437 on its findings and recommendations to the joint standing committee of
438 the General Assembly having cognizance of matters relating to
439 insurance, in accordance with the provisions of section 11-4a of the
440 general statutes. The task force shall terminate on the date that it
441 submits such report or February 1, 2024, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2023*	New section
Sec. 2	*October 1, 2023*	New section
Sec. 3	*October 1, 2023*	New section
Sec. 4	*October 1, 2023*	38a-567
Sec. 5	*from passage*	New section

Statement of Legislative Commissioners:
In Section 1, the definitions were reordered for consistency with standard drafting conventions.

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 24 $	FY 25 $
Connecticut Health Insurance Exchange	Resources of the Exchange - Revenue Loss	Potential Significant	Potential Significant
Insurance Dept.	IF - Cost	None	See Below
Department of Revenue Services	GF - Potential Revenue Loss	None	See Below

Note: IF=Insurance Fund; GF=General Fund

Municipal Impact: None

Explanation

The bill authorizes two forms of association health plans that are not permitted under current law: (1) a fully insured multiple employer welfare arrangement (MEWA) that is regulated as part of the large group health insurance market, and (2) a self-funded MEWA that administers a health benefit plan that is not insurance.

The bill results in (1) new costs to the Insurance Department (DOI) associated with regulating the plans beginning in FY 25, (2) a potential revenue loss to the General Fund associated with insurance premiums tax beginning in FY 25, and (3) a potentially significant revenue loss to the Connecticut Health Insurance Exchange ("exchange") beginning in FY 24.

The bill also creates a task force to study stop loss insurance and report on its findings and recommendations by February 1, 2024, which is not anticipated to result in a fiscal impact.

State Regulation Cost

The total annual costs for state regulation of self-funded MEWAs will depend on the number of such entities that are established; however, the cost per year to DOI is anticipated to be approximately $17,000 each. Due to the effective date of the bill and time necessary for DOI to adopt licensing regulations, these costs are not anticipated to begin until FY 25.[1]

The estimate reflects the staff time, at both analyst and supervisor hourly rates, anticipated to be required to handle the new volume of work, including time spent: (1) performing quarterly analysis and review, (3) reviewing requests for approvals, and (3) meeting with the companies as needed.

To the extent many such self-funded MEWAs are established, DOI would incur costs by hiring additional staff, resulting in salary and fringe benefit costs to the Insurance Fund. If the number of MEWAs is small, the agency is likely to rely on consultants to supplement staff capacity, resulting in contract costs of approximately $17,000 per entity annually.

The bill requires the DOI to adopt implementing regulations, which has no fiscal impact because the agency has the necessary expertise. The bill does not specify licensing and filing fees, therefore any revenue gain associated with those activities would result from the regulations.

State Tax and Exchange Revenue Impacts

The bill may result in a change to the amount of net direct written premiums in the fully insured small group market beginning in FY 24, to the extent small employers currently purchasing that insurance begin participating in the two types of association health plans permitted

[1] Fully insured MEWAs are not anticipated to increase DOI costs.

under the bill.[2]

Significant uptake of self-funded MEWAs by small employers currently in the fully insured market could reduce the total amount of net direct written premium that is taxed by the state beginning in FY 25, as health plans offered by self-funded MEWAs are not an insurance product.[3]

The insurance premiums tax is levied at a rate of 1.5% on all net direct premiums underwritten. The Department of Revenue Services collected $204.7 million from the insurance premiums tax in FY 22; it is uncertain how much of that revenue is from policies that could be affected by the bill.

Significant uptake of either type of MEWA could reduce exchange revenue substantially by reducing the base for its marketplace assessment. The operations of the exchange are almost entirely funded by its marketplace assessments, which are charged at a rate of 1.65% on premiums in the fully insured individual and small group markets.

The exchange marketplace assessment totals approximately $31.4 million for FY 23, with small group premiums accounting for 48% of that revenue (approximately $15.2 million). If there was a 10% reduction in fully insured small group premiums as a result of the bill, exchange revenue would be anticipated to decrease by approximately $1.5 million. For context, fully insured small group plan enrollment was 107,652 in 2021.[4]

Given that fully insured small group market enrollment has been decreasing in recent years, further enrollment reductions from the bill

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[2] Because self-funded MEWAs cannot operate without a license and DOI must adopt licensing regulations, shifts of insurance premiums to self-insured MEWAs are unlikely to occur before the last quarter of FY 24.

[3] Significant uptake of fully insured MEWA benefit plans would shift current spending on insurance premiums in the small group market to the large group market, which is not part of the base for the exchange's assessment.

[4] Connecticut Insurance Department, *2022 Consumer Report Card on Health Insurance Carriers*. Individual plan enrollment was 109,471 in 2021.

could contribute to a smaller, deteriorating risk pool for those small employers remaining in the fully insured small group market.

Insurance Fund Assessments

The bill does not impact the revenue to be collected by the three assessments that support the Insurance Fund (i.e., the general assessment, the Health and Welfare Fee, and the Public Health Fee), except to the extent that more revenue is needed to support DOI costs for regulating self-funded MEWAs. These assessments begin with the total amount of revenue needed and divide responsibility for that total amount amongst insurers, HMOs, and in the case of the Health and Welfare Fee, third-party administrators on behalf of the self-funded plans they administer.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to: (1) inflation, (2) the number of self-funded MEWAs that get licensed by DOI, (3) shifts in insurance coverage from the fully insured small group market to both the self-funded and large group markets, and (4) changes in employee wage and benefit costs, to the extent DOI hires new staff.

OLR Bill Analysis
sHB 6710

AN ACT CONCERNING ASSOCIATION HEALTH PLANS AND ESTABLISHING A TASK FORCE TO STUDY STOP-LOSS INSURANCE.

SUMMARY

This bill establishes a regulatory structure that allows self-funded and fully insured multiple employer welfare arrangements (MEWAs) to be sold in Connecticut. In practice, a MEWA is a group of employers (i.e., "employer members") that join together (i.e., into a "sponsoring association") to provide health benefit plans to the members' employees.

The bill requires MEWAs to meet certain minimum benefit standards, including covering the essential health benefits and any state mandated health insurance benefits and having an actuarial value of at least 60%. Additionally, self-insured MEWAs must be licensed with the Connecticut Insurance Department and meet certain fiduciary requirements. The bill subjects fully insured MEWAs to the large group health insurance rating requirements, rather than the small group requirements that apply to certain association health plans under current law. However, the bill requires both self-funded and fully insured MEWAs to comply with certain federal laws, which generally establish minimum consumer protections (see BACKGROUND).

Under the bill, a MEWA is comprised of "employer members," which are entities of a sponsoring association that conducts business and employs people in Connecticut. A "sponsoring association" is an industry trade group (or another group representing employers in multiple trades) that (1) is organized and has a written constitution or bylaws, (2) has at least 50 employer members, and (3) has been

maintained in good faith for at least the preceding five years for reasons other than providing insurance. Broadly, a fully insured MEWA purchases insurance from, and transfers risk to, a licensed insurer; a self-funded MEWA does not purchase an insurance plan and instead administers a benefit plan itself (i.e., pays claims from its own money).

The bill also establishes a 12-member task force to study whether stop-loss insurance may impact (1) small group health insurance plans and their enrollees and (2) medical spending in Connecticut. In practice, stop-loss insurance protects insureds from catastrophic claims by covering claims above a pre-set threshold. The bill requires the task force to report its findings to the Insurance and Real Estate Committee by February 1, 2024. The task force terminates on that date or when it submits its report, whichever is later.

EFFECTIVE DATE: October 1, 2023, except the task force provisions are effective upon passage.

§§ 1 & 2 — SELF-FUNDED MEWAS

The bill prohibits a self-funded MEWA from issuing a health benefit plan in Connecticut unless it first gets a license from the insurance commissioner. (The bill does not establish a licensure application, approval process, or fee.)

Under the bill, a "self-funded MEWA" is a health benefit plan that is (1) offered by a sponsoring association to provide insurance to its participating employer members and (2) not fully insured by a Connecticut-licensed insurer.

Minimum Coverage Requirements

The bill requires self-funded MEWAs that cover one or more employees of one or more participating employer members to:

1. cover the federal Affordable Care Act's essential health benefits, as required by federal law;

2. cover all state mandated health insurance coverage requirements

(i.e., benefit mandates);

3. offer coverage with a minimum of 60% actuarial value, which is the average percentage of an individual's health care costs that a plan pays;

4. cover inpatient hospital services and physician services;

5. not limit or exclude coverage based on preexisting conditions, which is also a federal law requirement;

6. not discriminate against insureds based on health status for health benefit plan eligibility, premiums, or contribution requirements;

7. make health benefit plans available to all employer members, regardless of any employer or employee health status factors; and

8. comply with existing law's utilization review and benefit determination notification requirements.

Rating Requirements

The bill requires self-funded MEWAs to:

1. set base rates formed on an actuarily sound, modified community rating methodology that considers the pooling of all participants' claims;

2. use each employer member's risk profile to set premiums by actuarily adjusting the base rate; and

3. use pooling or reinsurance of individual large claimants to reduce the adverse impact on any specific employer member's premiums.

Plan Design

The bill requires self-funded MEWAs to implement value-based insurance design and value-based contracting, which may include

centers of excellence, wellness programs, health enhancement programs, alternative payment models, chronic disease navigation, patient-centered medical homes, and advanced primary care.

Under the bill, "value-based insurance design" is any material term in a health insurance policy that is designed to increase the quality of covered benefits or health care services while reducing their cost.

Trust Requirements

The bill requires a sponsoring association to form a trust to establish and maintain the health benefit plan. However, the bill prohibits a trust from including in its name the words "insurance," "insurer," "underwriter," "mutual," or any other description of insurance or an insurance company, unless the context specifies that the trust is not an insurer or transacting insurance. Additionally, all health benefit plan documents a self-funded MEWA issues must include the following statement on the first page in bold 14-point type:

> "This coverage is not insurance and is not offered through an insurance company. This coverage is not required to comply with certain federal market requirements for health insurance, and is not required to comply with certain state laws for health insurance. Each employer member shall be liable for such employer member's allocated share of the liabilities of the sponsoring association under the health benefit plans as determined by the board of trustees. Each employer member may be responsible for paying an additional sum if the annual premiums present a deficit of funds for the trust. The trust's financial documents shall be made available upon request by a participant in the health benefit plan."

The trust is authorized to sell health benefit plans to the employer members if the trust:

1. is subject to ERISA (the Employee Retirement Income Security Act) and any regulations or standards the U.S. Department of Labor (DOL) prescribes related to MEWAs; and

2. annually files Form M-1 with DOL (DOL requires MEWAs to file this form, which generally identifies the sponsoring association and has a description of the plans it offers).

The bill requires the trust's organizational documents to:

1. state that the trust is sponsored by the sponsoring association;
2. state that the trust's purpose is to provide health care benefits, including medical, prescription drug, dental, and vision benefits, to the members' employees and their dependents;
3. require that the trust's funds be used for the participating employees' benefit (and the benefit of their dependents) through (a) self-funding claims or purchasing reinsurance, or a combination of both, and (b) defraying the health benefit plan's administration costs and expenses;
4. limit participation in a health benefit plan to participating employees of the sponsoring association and their employee members;
5. implement a process for electing trustees to the board; and
6. require trustees to discharge their duties following commonly accepted fiduciary standards as the commissioner requires by regulations.

Board of Trustees

The bill also requires the trust documents to establish and maintain a board of at least five trustees that have fiscal control over the self-funded MEWA. Under the bill, the board has the authority to (1) approve employer member applications to participate in the MEWA and (2) contract with any licensed administrator or service company to administer the MEWA's daily operations (e.g., a third-party administrator).

The bill requires the board to (1) operate any health benefit plan

following generally accepted fiduciary standards as the commissioner adopts in regulations and (2) have the authority to enforce and collect special assessments against employer members.

Minimum Reserves

The bill requires the trust to establish and maintain reserves calculated according to (1) the National Association of Insurance Commissioners Accounting Practices and Procedures Manual requirements and (2) any financial and solvency regulations the commissioner adopts.

Stop-Loss Insurance

Under the bill, a trust must purchase and maintain stop-loss insurance with retention levels set in keeping with actuarial principles from Connecticut-licensed insurers.

Fiduciary Liability Insurance and Bond

The bill also requires the trust to purchase and maintain:

1. commercially reasonable fiduciary liability insurance from a Connecticut-licensed insurer and

2. a bond, in a form and amount the commissioner approves.

Employer Member Liability

The bill makes each employer member liable for their allocated share of the sponsoring association's benefit plan liabilities, as the board of trustees determines.

Fully Insured Exemption

The bill regulates fully insured MEWAs separately (see below). As such, it specifies that the provisions above do not apply to them.

Regulations

The bill authorizes the commissioner to adopt implementing regulations, including requirements for licensing, financial condition and actuarial standards, solvency and insolvency, transparency and

reporting, and filing.

§§ 1, 3 & 4 — FULLY INSURED MEWAS

A "fully insured MEWA" is a health benefit plan (1) offered by a sponsoring association to provide insurance to the participating employers' employees and (2) funded through an insurance policy purchased from a Connecticut-licensed insurer.

Constitution and Bylaws (§ 3)

The bill requires a sponsoring association that sponsors a fully insured MEWA to have a written constitution and bylaws. These documents must require the sponsoring association to:

1. hold regular meetings, at least annually, to further its participating employers' purposes and
2. collect dues or solicit contributions from the participating employers.

Minimum Coverage Requirements (§ 3)

A fully insured MEWA must:

1. comply with all pertinent DOL regulations or standards,
2. qualify as a large group market plan subject to (a) all state health insurance benefit mandates and (b) all large group market regulations under the federal Public Health Service Act (see BACKGROUND),
3. adhere to all federal Affordable Care Act requirements applicable to large group plans,
4. not limit or exclude coverage for individuals based on preexisting conditions,
5. cover the Affordable Care Act's essential health benefits,
6. offer coverage that meets at least a 60% actuarial value, and

7. be available only to the MEWA's participating employers.

Fully Insured MEWAs as Large Employers (§ 4)

Current law allows an association health plan to provide health insurance to small employers subject to the small employer rating requirements. Insurance Bulletin HC-123 defines a "small employer" as between one and 50 employees (excluding sole proprietors).

The bill repeals this option for an association health plan to offer small group coverage. Instead, the bill subjects fully insured MEWAs to the large group requirements.

Among other things, this exempts fully insured MEWAs from requirements related to:

1. guaranteed issue and renewability (although the federal Affordable Care Act requires group insurers to offer coverage on both a guaranteed issue and guaranteed renewal basis) and

2. certain rating requirements, including that the association must be rated as a single pool, but may be adjusted by age and geographic area, as well as by actuarily justified differences in plan design, provider network, and administrative expenses.

§ 5 — STOP-LOSS INSURANCE TASK FORCE

The bill establishes a 12-member task force to study the structure of stop-loss insurance plans, including the impact they might have on (1) small groups and their enrollees, and (2) medical spending in Connecticut. For the purposes of this task force, a "small group" is an employer or other stop-loss purchaser with less than 100 employees or members and a "stop-loss insurance plan" is an insurance policy purchased by an employer, insurer, MEWA, or other provider of self-funded or fully insured group health coverage in Connecticut that limits the financial risk of medical claims.

The task force must make recommendations about:

1. how to ensure access to affordable health care services to stop-

loss insurance purchasers and their enrollees;

2. any financial impact that stop-loss insurance plans may have on small groups in Connecticut, enrollees and their family members, and the fully insured health insurance market in Connecticut;
3. the appropriate role of stop-loss insurance plans in this state; and
4. consumer protections for small groups and their enrollees and the enrollees' family members covered by stop-loss insurance plans in this state.

Task Force Members

Under the bill, the task force consists of the following members:

1. two members appointed by the House speaker, one representing a small group in Connecticut using stop-loss insurance, and the other representing a small group not using stop-loss insurance;
2. two members appointed by the Senate president pro tempore, one who has experience managing employee benefits and is knowledgeable about stop-loss insurance in Connecticut, and the other who is a Connecticut-licensed insurance producer with knowledge of stop-loss insurance;
3. one Connecticut-license physician appointed by the House majority leader;
4. one representative of a health equity advocacy organization, appointed by the Senate majority leader;
5. one Connecticut Association of Health Plans representative, appointed by the House minority leader;
6. one Connecticut Business and Industry Association representative, appointed by the Senate minority leader;
7. the Healthcare Advocate or his designee; and

8. three members appointed by the governor, one representing a labor organization, one representing an insurer licensed to issue stop-loss in Connecticut, and one representing a consumer advocacy organization.

The bill requires the appointing authorities to make their initial appointments within 30 days of the bill's passage and fill any vacancies.

Task force members must select one or two chairpersons from among the members. The chairperson(s) must schedule the first meeting of the task force, which must be held within 60 days of the bill's passage.

Under the bill, the Insurance and Real Estate Committee staff serve as the task force's administrative staff.

BACKGROUND

Federal ERISA, Title 1

Although self-funded (also called self-insured) health benefit plans are generally exempt from state regulation, federal law explicitly allows states to regulate self-funded MEWAs as long as state law does not violate Title 1 of ERISA. Title 1 of ERISA imposes several requirements on self- and fully insured plans, including requiring the plan to:

1. provide summary plan documents to enrollees;
2. meet certain fiduciary standards and requirements relating to plan administration;
3. provide certain remedies for participants who believe the plan has violated ERISA requirements;
4. provide continuation of coverage (i.e., COBRA) benefits;
5. prohibit discrimination based on preexisting conditions;
6. provide special enrollment periods to eligible individuals;
7. prohibit charging individuals higher premiums based on health factors;

8. include guaranteed renewability provisions; and

9. cover specified benefits (e.g., maternity and newborn benefits, mental health parity, breast reconstruction).

ERISA Title 1 also incorporates certain Affordable Care Act market reforms, which apply the Public Health Services Act (42 U.S.C. 2791) to the large group market. For fully insured MEWAs, this includes an 85% medical loss ratio.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 9 Nay 3 (03/14/2023)