AN ACT CONCERNING ASSOCIATION HEALTH PLANS.

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

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

(1) "Commissioner" means the Insurance Commissioner;

(2) "Fully insured multiple employer welfare arrangement" means any health benefit plan offered by a sponsoring association for the purpose of providing insurance to participating employees of a sponsoring association that is funded through a policy of insurance issued by a licensed insurance company in this state;

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

(4) "ERISA" means the Employee Retirement Income Security Act of
15 1974, as amended from time to time;

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

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

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

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

32 (b) Any health benefit plan issued by a self-funded multiple
33 employer welfare arrangement that covers one or more employees of
34 one or more participating employer members of a sponsoring
35 association shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) The trust shall purchase and maintain an insurance policy providing coverage for stop-loss insurance with retention levels determined in accordance with actuarial principles from insurers licensed to transact the business of insurance in this state;

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

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

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

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

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

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

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

(f) Health benefit plan documents issued by any such self-funded multiple employer welfare arrangement shall have the following statement printed on the first page in fourteen-point boldface 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 member shall be liable for such member's allocated share of the liabilities of the sponsoring association under the health benefit plans as determined by the board of trustees. Each 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".

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

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

Sec. 3. (NEW) (Effective October 1, 2023) (a) Any sponsoring association that sponsors any fully insured multiple employer welfare arrangement shall have a written constitution and bylaws that require:
(1) The sponsoring association to hold regular meetings not less than once annually to further the purposes of such sponsoring association's participating employers; and

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

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

(1) Comply with regulations or standards prescribed by the United States Department of Labor pertaining to multiple employer welfare arrangements;

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

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

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

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

(6) Offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to not less than sixty per cent of the full actuarial value of the benefits provided under the health benefit plan; and
(7) Be available only to participating employers of the fully insured
multiple employer welfare arrangement.

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

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

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

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

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

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

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

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

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

(ii) Gender;

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

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

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

(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

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

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

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

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

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

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

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

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

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

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

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

(5) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

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

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

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

(9) Any violation of subdivisions (3) to (7), inclusive, of this section and of any regulations established under subdivision (8) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.
This act shall take effect as follows and shall amend the following sections:

<table>
<thead>
<tr>
<th>Section</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1</td>
<td>October 1, 2023</td>
<td>New section</td>
</tr>
<tr>
<td>Sec. 2</td>
<td>October 1, 2023</td>
<td>New section</td>
</tr>
<tr>
<td>Sec. 3</td>
<td>October 1, 2023</td>
<td>New section</td>
</tr>
<tr>
<td>Sec. 4</td>
<td>October 1, 2023</td>
<td>38a-567</td>
</tr>
</tbody>
</table>

**Statement of Purpose:**
To authorize self-funded and fully insured multiple employer welfare arrangements in this state.

[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.]