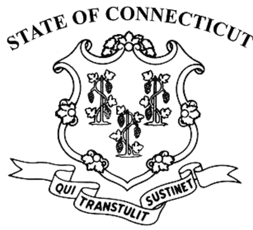

General Assembly **Amendment**

January Session, 2023 LCO No. **9466**

Offered by:

REP. WOOD K., 29th Dist.
REP. BARRY, 31st Dist.
REP. PAVALOCK-D'AMATO, 77th Dist.
REP. DENNING, 42nd Dist.
REP. DELNICKI, 14th Dist.
REP. MESKERS, 150th Dist.
REP. NUCCIO, 53rd Dist.
SEN. HWANG, 28th Dist.

To: Subst. House Bill No. **6710** File No. 330 Cal. No. 229

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

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1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective October 1, 2023*) For the purposes of this
4 section and sections 2 and 4 of this act:

5 (1) "Commercial domicile" means the headquarters of a trade or
6 business that is the place from which such trade or business is
7 principally managed and directed;

8 (2) "Commissioner" means the Insurance Commissioner;

9 (3) "Employer member" means an entity domiciled in this state or that
10 maintains its commercial domicile in this state, is a member of a

11 sponsoring association and employs more than one individual in this
12 state. "Employer member" may include such employer member's
13 sponsoring association, provided such sponsoring association is
14 domiciled in this state and employs more than one individual in this
15 state;

16 (4) "ERISA" means the Employee Retirement Income Security Act of
17 1974, as amended from time to time;

18 (5) "Health benefit plan" means a contract, certificate or agreement
19 offered, delivered, issued for delivery, renewed, amended or continued
20 in this state by a self-funded multiple employer welfare arrangement
21 trust to provide, deliver, arrange for, pay for or reimburse any of the
22 costs of the diagnosis, prevention, treatment, cure or relief of a health
23 condition, illness, injury or disease. "Health benefit plan" does not
24 include insurance products;

25 (6) "Health enhancement program" means any health benefit
26 program that ensures access and removes barriers to essential, high-
27 value clinical services;

28 (7) "Insurance" has the same meaning as provided in section 38a-1 of
29 the general statutes;

30 (8) "Manual rate" means a rate that is based on the average cost of a
31 health benefit plan for participating employers, adjusted for specific
32 participating employers participating in the self-funded multiple
33 employer welfare arrangement based on such participating employers'
34 case characteristics;

35 (9) "Multiple employer welfare arrangement trust" means any trust
36 established by a sponsoring association in accordance with subsection
37 (e) of section 2 of this act;

38 (10) "Participating employee" means any employee of a participating
39 employer that enrolls in a health benefit plan offered by a self-funded
40 multiple employer welfare arrangement trust;

41 (11) "Participating employer" means any employer member that
42 participates in a self-funded multiple employer welfare arrangement;

43 (12) "Preexisting conditions provision" has the same meaning as
44 provided in section 38a-476 of the general statutes;

45 (13) "Self-funded multiple employer welfare arrangement" means a
46 program established or maintained on behalf of employer members and
47 offered by a self-funded multiple employer welfare arrangement trust
48 for the purpose of providing one or more health benefit plans for such
49 employer member's employees and such employees' dependents;

50 (14) "Sponsoring association" means any industry trade group or any
51 other trade group with employer members representing multiple trades
52 domiciled in this state that (A) is organized and has a written
53 constitution or bylaws, (B) has not less than five hundred employees of
54 not less than twenty-five employer members, and (C) has been
55 maintained in good faith for not less than the immediately preceding
56 five years for purposes other than obtaining or providing insurance; and

57 (15) "Value-based health benefit plan design" means any material
58 term in a health benefit plan that is designed to increase the quality of
59 covered benefits or health care services while reducing the cost of such
60 health benefit plan or health care services.

61 Sec. 2. (NEW) (*Effective October 1, 2023*) (a) No person, other than a
62 self-funded multiple employer welfare arrangement trust, shall
63 establish or operate a self-funded multiple employer welfare
64 arrangement in this state.

65 (b) Any self-funded multiple employer welfare arrangement trust,
66 prior to establishing a self-funded multiple employer welfare
67 arrangement in this state, shall apply for and obtain a license from the
68 commissioner. The commissioner shall issue a license to such self-
69 funded multiple employer welfare arrangement trust, provided such
70 trust satisfies all licensing requirements applicable to a health insurance
71 company pursuant to chapter 698 of the general statutes. Upon the

72 issuance of a license by the commissioner to a self-funded multiple
73 employer welfare arrangement trust, in accordance with the provisions
74 of this subsection, such trust shall comply with all requirements
75 applicable to health insurance companies set forth in title 38a of the
76 general statutes, and any regulations adopted by the commissioner, in
77 accordance with the provisions of chapter 54 of the general statutes.

78 (c) (1) The commissioner shall not issue a license to a self-funded
79 multiple employer welfare arrangement trust pursuant to subsection (b)
80 of this section, unless such trust has an initial combined capital and
81 surplus of not less than four million dollars.

82 (2) Beginning on April 1, 2024, any self-funded multiple employer
83 welfare arrangement trust that meets the licensing requirements
84 pursuant to subdivision (1) of this subsection and subsection (b) of this
85 section may offer a health benefit plan to participating employees of one
86 or more participating employers.

87 (d) Any health benefit plan issued by a self-funded multiple
88 employer welfare arrangement trust that covers participating
89 employees of one or more participating employers shall:

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

95 (2) Offer to each participating employer health benefit plans with a
96 minimum level of coverage designed to provide health benefits that are
97 actuarially equivalent to not less than sixty per cent, not less than sixty-
98 eight per cent and not less than seventy-eight per cent of the full
99 actuarial value of the benefits provided under each health benefit plan;

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

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

105 (5) Establish base rates formed on an actuarially sound, modified
106 community rating methodology that considers the pooling of all
107 participating employees' claims;

108 (6) Utilize each participating employer's risk profile to determine
109 rates by actuarially adjusting above or below established base rates, and
110 utilize pooling or reinsurance of individual large claims to reduce the
111 adverse impact on any specific participating employer's rates. The self-
112 funded multiple employer welfare arrangement trust shall establish the
113 applicable pooling point, which shall consistently apply to all such
114 participating employers;

115 (7) Limit any participating employer's new business rates to not more
116 than thirty per cent above or forty per cent below such health benefit
117 plan's manual rate plus any adjustment due to coverage or case
118 characteristics of the participating employer;

119 (8) For a renewing participating employer in a new rating period,
120 limit any percentage increase in the rate charged for a health benefit plan
121 to a participating employer to an amount that shall not exceed the sum
122 of the following:

123 (A) The percentage change in the new business manual rate,
124 measured from the first day of the immediately preceding rating period
125 to the first day of the new rating period. In the case of a health benefit
126 plan where the self-funded multiple employer welfare arrangement
127 trust is no longer enrolling new participating employers, such self-
128 funded multiple employer welfare arrangement trust shall use the
129 percentage adjustment in the base rate, provided such adjustment does
130 not exceed, on a percentage basis, the adjustment in the new business
131 rate for a comparable health benefit plan in which the self-funded
132 multiple employer welfare arrangement trust is enrolling new
133 participating employers;

134 (B) Any adjustment, not to exceed (i) twenty-five per cent until the
135 participation in the self-funded multiple employer welfare arrangement
136 exceeds five thousand participating employees, (ii) twenty per cent
137 when the self-funded multiple employer welfare arrangement
138 participation is between five thousand one and fifteen thousand
139 participating employees, and (iii) fifteen per cent when the self-funded
140 multiple employer welfare arrangement participation exceeds fifteen
141 thousand participating employees, adjusted pro rata for rating periods
142 that do not exceed one year, of the new business rate for the new rating
143 period; and

144 (C) Any adjustment due to change in coverage or change in the case
145 characteristics of the participating employer;

146 (9) Allow a self-funded multiple employer welfare arrangement trust
147 to submit a written request to the commissioner for such trust to deviate
148 from the requirements of subdivisions (7) and (8) of this subsection due
149 to solvency or financial condition considerations. Not later than ninety
150 calendar days after the commissioner receives such written request from
151 such self-funded multiple employer welfare arrangement trust, the
152 commissioner shall issue a decision granting or denying such request;

153 (10) Use surplus in excess of an amount to be determined by the
154 commissioner on an annual basis, to reduce health benefit plan
155 contribution amounts paid by participating employers and
156 participating employees;

157 (11) Make any health benefit plan available to all participating
158 employers regardless of any factor relating to the health status of such
159 participating employer or individuals eligible for coverage through any
160 participating employer;

161 (12) Implement value-based health benefit plan design and value-
162 based contracting by administering programs, which may include, but
163 need not be limited to, centers of excellence, wellness programs, health
164 enhancement programs, alternative payment models, chronic disease
165 navigation and patient-centered medical homes. Beginning on August

166 1, 2024, each self-funded multiple employer welfare arrangement trust
167 shall annually report, on a form provided by the Insurance
168 Commissioner, such implementation of value-based health benefit plan
169 design and value-based contracting pursuant to this subdivision. Such
170 report to the Insurance Commissioner shall include the following: (A) A
171 description of such value-based health benefit plan design and value-
172 based contracting programs; (B) the number of participating employees
173 enrolled in such value-based health benefit plan design and value-based
174 contracting programs; (C) the percentage of dollars spent on such value-
175 based health benefit plan design and value-based contracting programs;
176 and (D) a description that explains how such value-based health benefit
177 plan design and value-based contracting programs lower costs for
178 participating employees enrolled in such programs; and

179 (13) With regard to participating employees, comply with the
180 notification requirements set forth in sections 38a-591c to 38a-591g,
181 inclusive, of the general statutes with respect to utilization review and
182 benefit determinations of a benefit request or claim.

183 (e) A sponsoring association shall form a self-funded multiple
184 employer welfare arrangement trust that shall establish, maintain and
185 offer health benefit plans for the self-funded multiple employer welfare
186 arrangement. Such trust shall be authorized to sell health benefit plans
187 to participating employers exclusively through insurance producers
188 licensed in accordance with chapter 702 of the general statutes, provided
189 such trust meets the following conditions:

190 (1) The self-funded multiple employer welfare arrangement trust
191 shall be subject to ERISA and any regulations or standards prescribed
192 by the United States Department of Labor pertaining to multiple
193 employer welfare arrangements;

194 (2) A Form M-1 shall be filed each year with the United States
195 Department of Labor. For purposes of this subdivision, "Form M-1"
196 means an annual report required by the United States Department of
197 Labor for multiple employer welfare arrangements that includes, but is

198 not limited to, the following: (A) Identification of the sponsoring
199 association and the self-funded multiple employer welfare arrangement
200 trust; and (B) a description of the health benefit plans offered through
201 such self-funded multiple employer welfare arrangement trust;

202 (3) Any organizational documents for a self-funded multiple
203 employer welfare arrangement trust shall:

204 (A) State that such self-funded multiple employer welfare
205 arrangement trust is sponsored by the sponsoring association;

206 (B) State that the purpose of such self-funded multiple employer
207 welfare arrangement trust is to provide health benefit plans to
208 participating employers, such participating employer's employees and
209 such employees' dependents;

210 (C) Provide that self-funded multiple employer welfare arrangement
211 trust funds shall be used for the benefit of participating employees and
212 such employees' dependents through (i) self-funding of claims or the
213 purchase of reinsurance, or any combination thereof, and (ii) defraying
214 the costs and expenses of administering and operating such self-funded
215 multiple employer welfare arrangement trust and any health benefit
216 plan issued by such trust;

217 (D) Limit participation in any health benefit plan to participating
218 employees and such employees' dependents;

219 (E) Establish and maintain a board of trustees, composed of not less
220 than five trustees, that shall have fiscal control over such self-funded
221 multiple employer welfare arrangement trust for the purpose of
222 managing all health benefit plans established, maintained and offered
223 by such self-funded multiple employer welfare arrangement trust. Any
224 board of trustees shall have the authority to contract with any licensed
225 administrator or service company to administer the daily operations of
226 the health benefit plans;

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

228 trustees; and

229 (G) Require each trustee to discharge such trustee's duties in
230 accordance with generally accepted fiduciary standards;

231 (4) The self-funded multiple employer welfare arrangement trust
232 shall establish and maintain reserves in accordance with any financial
233 and solvency requirements applicable to health insurance companies set
234 forth in title 38a of the general statutes, and any regulations adopted by
235 the commissioner, in accordance with the provisions of chapter 54 of the
236 general statutes;

237 (5) The self-funded multiple employer welfare arrangement trust
238 shall purchase and maintain an insurance policy providing coverage for
239 stop-loss insurance for each health benefit plan with retention levels
240 determined in accordance with actuarial principles from insurers
241 licensed to transact the business of insurance in this state;

242 (6) The self-funded multiple employer welfare arrangement trust
243 shall purchase and maintain an aggregate stop-loss insurance policy
244 with an attachment point equal to one hundred twenty-five per cent of
245 losses. The self-funded multiple employer welfare arrangement trust
246 may submit a written request to the commissioner to modify the
247 aggregate stop-loss policy. Not later than thirty calendar days after the
248 commissioner receives such request, the commissioner shall issue a
249 decision granting or denying such request;

250 (7) The self-funded multiple employer welfare arrangement trust
251 shall purchase and maintain commercially reasonable fiduciary liability
252 insurance from insurers licensed to transact the business of insurance in
253 this state;

254 (8) The self-funded multiple employer welfare arrangement trust
255 shall purchase and maintain a bond in an amount and form approved
256 by the commissioner; and

257 (9) No self-funded multiple employer welfare arrangement trust shall

258 include in its name the words "insurance", "insurer", "underwriter",
259 "mutual" or any other word or term or combination of words or terms
260 that is descriptive of an insurance company or insurance business,
261 unless the context of such words or terms indicates that such self-funded
262 multiple employer welfare arrangement trust is not an insurance
263 company and is not transacting the business of insurance.

264 (f) Any board of trustees established pursuant to subsection (e) of this
265 section shall:

266 (1) Operate any health benefit plans in accordance with generally
267 accepted fiduciary standards; and

268 (2) Pay all costs assessed by the commissioner in accordance with title
269 38a of the general statutes. Such board of trustees shall have the
270 authority to collect fees on a pro rata basis from the participating
271 employers. No self-funded multiple employer welfare arrangement
272 trust shall be subject to (A) the health and welfare fee required under
273 section 19a-7j of the general statutes, (B) the public health fee required
274 under section 19a-7p of the general statutes, (C) any payment required
275 under section 38a-48 of the general statutes, or (D) the premium tax
276 required under section 12-202 of the general statutes.

277 (g) Each participating employer shall be (1) liable for such
278 participating employer's allocated share of the liabilities arising under a
279 health benefit plan provided by the self-funded multiple employer
280 welfare arrangement trust, as determined by the board of trustees, and
281 (2) jointly and severally liable for additional amounts if the annual
282 health benefit plan subscription amounts paid by all participating
283 employers of such plan result in a deficit of funds for the self-funded
284 multiple employer welfare arrangement trust. Each participating
285 employer's liability under this subsection shall not be assessed to
286 participating employees of such participating employer.

287 (h) Health benefit plan documents issued by any self-funded multiple
288 employer welfare arrangement trust to participating employers shall
289 have the following statement printed on the first page in fourteen-point

290 boldface type: "This health benefit plan is provided by a trust
291 established to provide health benefit plans to employees of employers
292 participating in a self-funded multiple employer welfare arrangement.
293 This health benefit plan is not insurance and is not offered through an
294 insurance company. This health benefit plan is not required to comply
295 with certain federal market requirements for health insurance, and is
296 not required to comply with certain state laws for health insurance. Each
297 participating employer shall be liable for such participating employer's
298 allocated share of the liabilities of the trust under all health benefit plans
299 offered by the trust, as determined by the board of trustees. Each
300 participating employer shall be jointly and severally liable for additional
301 amounts if the annual health benefit plan subscription amounts paid by
302 all participating employers and participating employees of such
303 participating employer result in a deficit of funds for the trust and for
304 any assessments by state regulators. The trust's financial statements
305 shall be made available upon request by any participating employer in
306 the self-funded multiple employer welfare arrangement".

307 (i) Health benefit plan documents issued by any self-funded multiple
308 employer welfare arrangement trust to participating employees shall
309 have the following statement printed on the first page in fourteen-point
310 boldface type: "This health benefit plan is provided by a trust
311 established to provide health benefit plans to employees of employers
312 participating in a self-funded multiple employer welfare arrangement,
313 including your employer. This health benefit plan is not insurance and
314 is not offered through an insurance company. This health benefit plan is
315 not required to comply with certain federal market requirements for
316 health insurance, and is not required to comply with certain state laws
317 for health insurance. Your employer shall be liable for such employer's
318 allocated share of the liabilities of the trust under all health benefit plans
319 offered by the trust, as determined by the board of trustees. Your
320 employer shall be jointly and severally liable for additional amounts if
321 the annual health benefit plan subscription amounts paid by all
322 participating employers and participating employees of such
323 participating employer result in a deficit of funds for the trust and for

324 any assessments by state regulators. The trust's financial statements
325 shall be made available to you upon request. The Consumer Affairs
326 Division within the Insurance Department is available to assist you with
327 questions that you may have concerning this health benefit plan". The
328 notice shall include the telephone number and electronic mail address
329 for the Consumer Affairs Division.

330 (j) No self-funded multiple employer welfare arrangement trust shall
331 be subject to the Connecticut Insurance Guaranty Association pursuant
332 to sections 38a-836 to 38a-853, inclusive, of the general statutes.

333 (k) The commissioner may adopt regulations, in accordance with the
334 provisions of chapter 54 of the general statutes, to implement the
335 provisions of this section.

336 Sec. 3. Section 38a-567 of the general statutes is repealed and the
337 following is substituted in lieu thereof (*Effective April 1, 2024*):

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

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

346 (B) Any such plan or arrangement shall be renewable with respect to
347 all eligible employees or dependents at the option of the small employer,
348 policyholder or contractholder, as the case may be, except: (i) For
349 nonpayment of the required premiums by the small employer,
350 policyholder or contractholder; (ii) for fraud or misrepresentation of the
351 small employer, policyholder or contractholder or, with respect to
352 coverage of individual insured, the insureds or their representatives;
353 (iii) for noncompliance with plan or arrangement provisions; (iv) when
354 the number of insureds covered under the plan or arrangement is less

355 than the number of insureds or percentage of insureds required by
356 participation requirements under the plan or arrangement; or (v) when
357 the small employer, policyholder or contractholder is no longer actively
358 engaged in the business in which it was engaged on the effective date of
359 the plan or arrangement.

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

374 (D) Any such plan or arrangement shall provide special enrollment
375 periods (i) to all eligible employees or dependents as set forth in 45 CFR
376 147.104, as amended from time to time, and (ii) for coverage under such
377 plan or arrangement ordered by a court for a spouse or minor child of
378 an eligible employee where request for enrollment is made not later than
379 thirty days after the issuance of such court order.

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

384 (B) With respect to grandfathered plans issued to small employers,
385 except as a member of an association of small employers, the premium
386 rates charged or offered shall be established on the basis of a single pool

387 of all grandfathered plans, adjusted to reflect one or more of the
388 following classifications:

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

391 (ii) Gender;

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

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

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

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

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

415 (viii) Family composition, provided the small employer carrier shall
416 utilize only one or more of the following billing classifications: (I)

417 Employee; (II) employee plus family; (III) employee and spouse; (IV)
418 employee and child; (V) employee plus one dependent; and (VI)
419 employee plus two or more dependents.

420 (C) (i) With respect to nongrandfathered plans issued to small
421 employers, except as a member of an association of small employers, the
422 premium rates charged or offered shall be established on the basis of a
423 single pool of all nongrandfathered plans, adjusted to reflect one or
424 more of the following classifications:

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

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

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

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

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

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

444 (A) Encouraging or directing small employers to refrain from filing
445 an application for coverage with the small employer carrier because of
446 the health status, claims experience, industry, occupation or geographic

447 location of the small employer, except the provisions of this
448 subparagraph shall not apply to information provided by a small
449 employer carrier or producer to a small employer regarding the carrier's
450 established geographic service area or a restricted network provision of
451 a small employer carrier; or

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

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

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

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

477 (7) If a small employer carrier enters into a contract, agreement or
478 other arrangement with another party to provide administrative,

479 marketing or other services related to the offering of health benefit plans
480 to small employers in this state, the other party shall be subject to the
481 provisions of this section.

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

486 (9) Any violation of subdivisions (3) to (7), inclusive, of this section
487 and of any regulations established under subdivision (8) of this section
488 shall be an unfair and prohibited practice under sections 38a-815 to 38a-
489 830, inclusive.

490 Sec. 4. (*Effective from passage*) (a) For the purposes of this section:

491 (1) "Stop-loss insurance plan" means any insurance policy purchased
492 by any employer, insurer, multiple employer welfare arrangement trust
493 or other provider of fully insured or self-funded small group health
494 coverage in this state that limits the financial risk of medical costs for
495 such employer, insurer, multiple employer welfare arrangement trust
496 or other provider of fully insured or self-funded small group health
497 coverage; and

498 (2) "Small group" means any employer or other purchaser of a stop-
499 loss insurance plan with not more than one hundred employees or
500 employers.

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

505 (c) The task force shall make recommendations concerning: (1)
506 Measures to ensure access to affordable health care services to
507 purchasers of stop-loss insurance plans and such purchasers' enrollees
508 in health coverage utilizing stop-loss insurance plans; (2) any financial

509 impact that stop-loss insurance plans may have on (A) small groups in
510 this state, (B) enrollees and such enrollees' family members, and (C) the
511 fully insured health insurance market in this state; (3) the appropriate
512 role of stop-loss insurance plans in this state; and (4) consumer
513 protections for small groups, such small groups' enrollees and such
514 enrollees' family members covered by stop-loss insurance plans in this
515 state.

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

517 (1) Two appointed by the speaker of the House of Representatives,
518 one of whom shall be a representative of a small group in this state
519 utilizing a stop-loss insurance plan, and one of whom shall be a
520 representative of a small group in this state offering health coverage that
521 does not utilize a stop-loss insurance plan;

522 (2) Two appointed by the president pro tempore of the Senate, one of
523 whom shall have experience in managing employee benefits and be
524 knowledgeable with respect to stop-loss insurance in this state, and one
525 of whom shall be an insurance producer licensed in this state and be
526 knowledgeable with respect to stop-loss insurance in this state;

527 (3) One appointed by the majority leader of the House of
528 Representatives, who shall be a physician licensed pursuant to chapter
529 370 of the general statutes;

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

532 (5) One appointed by the minority leader of the House of
533 Representatives, who shall be a representative of the Connecticut
534 Association of Health Plans;

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

537 (7) The Healthcare Advocate, or the Healthcare Advocate's designee;

538 (8) The Insurance Commissioner, or the commissioner's designee;

539 (9) The executive director of the Office of Health Strategy, or the
540 executive director's designee; and

541 (10) Three persons appointed by the Governor, one of whom shall be
542 a representative of a labor organization, one of whom shall be a
543 representative of an insurance carrier licensed to issue stop-loss
544 insurance plans in this state and one of whom shall be a representative
545 of a consumer advocacy organization.

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

549 (f) The members of the task force shall select one or two chairpersons
550 of the task force from among the members of the task force. Such
551 chairperson or chairpersons shall schedule the first meeting of the task
552 force, which shall be held not later than sixty days after the effective date
553 of this section.

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

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

563 Sec. 5. Subsection (a) of section 38a-9 of the general statutes is
564 repealed and the following is substituted in lieu thereof (*Effective October*
565 *1, 2023*):

566 (a) Notwithstanding the provisions of section 4-8, there shall be a
567 Division of Consumer Affairs within the Insurance Department, which

568 division shall act on the Insurance Commissioner's behalf and at his
569 direction in order to carry out his responsibilities under this title with
570 respect to such matters. The division shall receive and review
571 complaints from residents of this state concerning their insurance
572 problems and problems arising out of health benefit plans, as defined in
573 subdivision (5) of subsection (a) of section 1 of this act, including claims
574 disputes, and serve as a mediator in such disputes in order to assist the
575 commissioner in determining whether statutory requirements and
576 contractual obligations within the commissioner's jurisdiction have
577 been fulfilled. There shall be a director of said division, who shall be
578 provided with sufficient staff. The division shall serve to coordinate all
579 appropriate facilities in the department in addressing such complaints,
580 and conduct any outreach programs deemed necessary to properly
581 inform and educate the public on insurance matters. The director shall
582 submit quarterly reports to the commissioner, which shall state the
583 number of complaints received by the division in such calendar quarter,
584 the Connecticut premium or premium equivalent volume of the
585 appropriate line of each insurance company or multiple employer
586 welfare arrangement trust, as defined in subdivision (9) of subsection
587 (a) of section 1 of this act, against which a complaint has been filed, the
588 types of complaints received, and the number of such complaints which
589 have been resolved. Such reports shall be published every six months
590 and copies shall be made available to any interested resident of this state
591 upon request. The commissioner shall report, in accordance with section
592 11-4a, to the joint standing committee of the General Assembly having
593 cognizance of matters relating to insurance on or before January
594 fifteenth annually, concerning the findings of such reports and
595 suggestions for legislative initiatives to address recurring problems.

596 Sec. 6. Section 38a-14 of the general statutes is repealed and the
597 following is substituted in lieu thereof (*Effective October 1, 2023*):

598 (a) For the purposes of this section, "company" means any insurance
599 company, multiple employer welfare arrangement trust, as defined in
600 subdivision (9) of subsection (a) of section 1 of this act, or health care
601 center doing business in this state, any corporation or association

602 collecting data utilized by any such insurance company in the
603 underwriting of insurance policies and any corporation organized
604 under any law of this state or having an office in this state, which
605 corporation is engaged in, or claiming or advertising that it is engaged
606 in, organizing or receiving subscriptions for or disposing of stock of, or
607 in any manner aiding or taking part in the formation or business of, an
608 insurance company or companies, or that is holding the capital stock of
609 one or more insurance corporations for the purpose of controlling the
610 management thereof, as voting trustees or otherwise.

611 (b) The commissioner shall, as often as the commissioner deems it
612 expedient, examine into the affairs of any company. In scheduling and
613 determining the nature, scope and frequency of the examinations, the
614 commissioner shall consider such matters as the results of financial
615 statement analyses and ratios, changes in management or ownership,
616 actuarial opinions, reports of independent certified public accountants
617 and such other criteria as set forth in the examiners' handbook adopted
618 by the National Association of Insurance Commissioners and in effect
619 at the time the commissioner exercises discretion under this section.

620 (c) (1) To carry out examinations under this section, the commissioner
621 may appoint one or more competent persons as examiners, who shall
622 not be officers of, connected with or interested in any company, other
623 than as policyholders. The commissioner may engage the services of
624 attorneys, appraisers, independent actuaries, independent certified
625 public accountants or other professionals and specialists as examiners
626 to assist the commissioner in conducting the examinations under this
627 section, the cost of which shall be borne by the company that is the
628 subject of the examination.

629 (2) In conducting the examination, the commissioner, the
630 commissioner's actuary or any examiner authorized by the
631 commissioner may examine, under oath, the officers and agents of such
632 a company, and all persons deemed to have material information
633 regarding the company's property or business. Each such company or
634 its officers and agents shall produce the books and papers in its or their

635 possession, relating to its business or affairs, and any other person may
636 be required to produce any book or paper in such person's custody that
637 is deemed to be relevant to such examination, for inspection by the
638 commissioner, the commissioner's actuary or examiners. The officers
639 and agents of the company shall facilitate the examination and aid the
640 examiners in making the same so far as it is in their power to do so. The
641 refusal of any company, by its officers, directors, employees or agents,
642 to submit to examination or to comply with any reasonable written
643 request of the examiners shall be grounds for suspension of, refusal of
644 or nonrenewal of any license or authority held by the company to
645 engage in an insurance or other business subject to the commissioner's
646 jurisdiction. Any such proceedings for suspension, revocation or refusal
647 of any license or authority shall be conducted pursuant to subsection (c)
648 of section 38a-41.

649 (3) In conducting the examination, the examiner shall observe those
650 guidelines and procedures set forth in the examiners' handbook
651 adopted by the National Association of Insurance Commissioners. The
652 commissioner may also adopt such other guidelines or procedures as
653 the commissioner may deem appropriate.

654 (d) In lieu of an examination under this section of any foreign or alien
655 insurer licensed in this state, the commissioner may accept an
656 examination report on such insurer prepared by the insurance
657 department for the insurer's state of domicile or port-of-entry state if (1)
658 such state's insurance department was, at the time of the examination,
659 accredited under the National Association of Insurance Commissioners'
660 financial regulation standards and accreditation program, or (2) the
661 examination is performed under the supervision of an accredited
662 insurance department or with the participation of one or more
663 examiners who are employed by such an accredited state insurance
664 department and who, after a review of the examination workpapers and
665 report, state under oath that the examination was performed in a
666 manner consistent with the standards and procedures required by their
667 insurance department.

668 (e) (1) Nothing contained in this section shall be construed to limit the
669 commissioner's authority to terminate or suspend any examination in
670 order to pursue legal or regulatory action pursuant to the insurance
671 laws of this state. Findings of fact and conclusions made pursuant to any
672 examination shall be prima facie evidence in any legal or regulatory
673 action.

674 (2) Nothing contained in this section shall be construed to limit the
675 commissioner's authority in such legal or regulatory action to use and,
676 if appropriate, to make public any final or preliminary examination
677 report, any examiner or company workpapers or other documents, or
678 any other information discovered or developed during the course of any
679 examination.

680 (3) Not later than sixty days following completion of the examination,
681 the examiner in charge shall file, under oath, with the Insurance
682 Department a verified written report of examination. Upon receipt of
683 the verified report, the Insurance Department shall transmit the report
684 to the company examined, together with a notice that shall afford the
685 company examined a reasonable opportunity, not to exceed thirty days,
686 to make a written submission or rebuttal with respect to any matters
687 contained in the examination report. Not later than thirty days after the
688 period allowed for the receipt of written submissions or rebuttals, the
689 commissioner shall fully consider and review the report, together with
690 any written submissions or rebuttals and any relevant portions of the
691 examiner's workpapers and enter an order: (A) Adopting the
692 examination report as filed or with modification or corrections. If the
693 examination report reveals that the company is operating in violation of
694 any law, regulation or prior order of the commissioner, the
695 commissioner may order the company to take any action the
696 commissioner considers necessary and appropriate to cure such
697 violation; (B) rejecting the examination report with directions to the
698 examiners to reopen the examination for purposes of obtaining
699 additional data, documentation or information, and refiling pursuant to
700 this subdivision; or (C) calling for an investigatory hearing with not less
701 than twenty days' notice to the company for purposes of obtaining

702 additional documentation, data, information and testimony.

703 (4) (A) The commissioner shall transmit the examination report
704 adopted pursuant to subparagraph (A) of subdivision (3) of this
705 subsection or a summary thereof to the company examined, together
706 with any recommendations or written statements from the
707 commissioner or the examiner. The secretary of the board of directors or
708 similar governing body of the company shall provide a copy of the
709 report or summary to each director and shall certify to the
710 commissioner, in writing, that a copy of the report or summary has been
711 provided to each director.

712 (B) Not later than one hundred twenty days after receiving the report
713 or summary, the chief executive officer or the chief financial officer of
714 the company examined shall present the report or summary to the
715 company's board of directors or similar governing body at a regular or
716 special meeting.

717 (f) (1) All orders entered pursuant to subdivision (3) of subsection (e)
718 of this section shall be accompanied by findings and conclusions
719 resulting from the commissioner's consideration and review of the
720 examination report, relevant examiner workpapers and any written
721 submissions or rebuttals. The findings and conclusions that form the
722 basis of any such order of the commissioner shall be subject to review as
723 provided in section 38a-19.

724 (2) Any investigatory hearing conducted under subparagraph (C) of
725 subdivision (3) of subsection (e) of this section by the commissioner or
726 the commissioner's authorized representative, shall be conducted as a
727 nonadversarial confidential investigatory proceeding as necessary for
728 the resolution of any inconsistencies, discrepancies or disputed issues
729 apparent (A) upon the filed examination report, (B) raised by or as a
730 result of the commissioner's review of relevant workpapers, or (C) by
731 the written submission or rebuttal of the company. Not later than
732 twenty days after the conclusion of any such hearing, the commissioner
733 shall enter an order pursuant to subparagraph (A) of subdivision (3) of

734 subsection (e) of this section. The commissioner shall not appoint an
735 examiner as an authorized representative to conduct the hearing. The
736 hearing shall proceed expeditiously with discovery by the company
737 limited to the examiner's workpapers that tend to substantiate any
738 assertions set forth in any written submission or rebuttal. The
739 commissioner or the commissioner's authorized representative may
740 issue subpoenas for the attendance of any witnesses or the production
741 of any documents deemed relevant to the investigation, whether under
742 the control of the department, the company or other persons. The
743 documents produced shall be included in the record and testimony
744 taken by the commissioner or the commissioner's authorized
745 representative shall be under oath and preserved for the record.
746 Nothing contained in this section shall require the department to
747 disclose any information or records that would indicate or show the
748 existence or content of any investigation or activity of a criminal justice
749 agency. The hearing shall proceed with the commissioner or the
750 commissioner's authorized representative posing questions to the
751 persons subpoenaed. Thereafter, the company and the Insurance
752 Department may present testimony relevant to the investigation. Cross-
753 examination shall be conducted only by the commissioner or the
754 commissioner's authorized representative. The company and the
755 Insurance Department shall be permitted to make closing statements
756 and may be represented by counsel of their choice.

757 (g) The commissioner may, if the commissioner deems it in the public
758 interest, publish any such report, or the result of any such examination
759 contained therein, in one or more newspapers of the state.

760 (h) The commissioner shall, at least once in every five years, visit and
761 examine the affairs of each domestic insurer, domestic health care
762 center, domestic fraternal benefit society, multiple employer welfare
763 arrangement trust, as defined in subdivision (9) of subsection (a) of
764 section 1 of this act and foreign and alien insurer doing business in this
765 state. Notwithstanding subdivision (1) of subsection (c) of this section,
766 no domestic insurer or such other domestic entity subject to examination
767 under this section shall pay as costs associated with the examination the

768 salaries, fringe benefits or travel and maintenance expenses of
769 examining personnel of the Insurance Department engaged in such
770 examination if such domestic insurer or domestic entity is otherwise
771 liable to assessment levied under section 38a-47, except that a domestic
772 insurer or such other domestic entity shall pay the travel and
773 maintenance expenses of examining personnel of the Insurance
774 Department when such insurer or entity is examined outside the state.

775 (i) Nothing contained in this section shall prevent or be construed as
776 prohibiting the commissioner from disclosing the content of an
777 examination report, preliminary examination report or results, or any
778 matter relating thereto, to the Insurance Department of this or any other
779 state or country, or to law enforcement officials of this or any other state
780 or to any agency of the federal government at any time, so long as such
781 agency or office receiving the report or matters relating thereto agrees,
782 in writing, to hold such report and matters relating thereto confidential.

783 (j) All workpapers, recorded information, documents and copies
784 thereof produced by, obtained by or disclosed to the commissioner or
785 any other person in the course of an examination made under this
786 section shall be confidential, shall not be subject to subpoena and shall
787 not be made public by the commissioner or any other person, except to
788 the extent provided in subsection (i) of this section. The commissioner
789 may grant access to such workpapers, recorded information, documents
790 and copies thereof to the National Association of Insurance
791 Commissioners, provided said association agrees, in writing, to hold
792 such workpapers, recorded information, documents and copies thereof
793 confidential.

794 (k) (1) The commissioner may from time to time engage, on an
795 individual basis, the services of qualified actuaries, certified public
796 accountants or other similar individuals who are independently
797 practicing their professions, even though said persons may from time to
798 time be similarly employed or retained by persons subject to
799 examination under this section.

800 (2) No cause of action shall arise nor shall any liability be imposed
801 against the commissioner, the commissioner's authorized
802 representatives or any examiner appointed by the commissioner for any
803 statements made or conduct performed in good faith while carrying out
804 the provisions of this section.

805 (3) No cause of action shall arise, nor shall any liability be imposed
806 against any person for the act of communicating or delivering
807 information or data to the commissioner or the commissioner's
808 authorized representative examiner pursuant to an examination made
809 under this section, if such act of communication or delivery was
810 performed in good faith and without fraudulent intent or the intent to
811 deceive.

812 (4) This section shall not abrogate or modify in any way any common
813 law or statutory privilege or immunity heretofore enjoyed by any
814 person identified in subdivision (2) of this subsection.

815 (5) A person identified in subdivision (2) of this subsection shall be
816 entitled to an award of attorney's fees and costs if such person is the
817 prevailing party in a civil action for libel, slander or any other relevant
818 tort arising out of activities in carrying out the provisions of this section
819 and the party bringing the action was not substantially justified in doing
820 so. For purposes of this section, a proceeding is "substantially justified"
821 if it had a reasonable basis in law or fact at the time that it was initiated.

822 Sec. 7. Section 38a-15 of the general statutes is repealed and the
823 following is substituted in lieu thereof (*Effective October 1, 2023*):

824 (a) The commissioner shall, as often as the commissioner deems it
825 expedient, undertake a market conduct examination of the affairs of any
826 insurance company, health care center, <u>multiple employer welfare</u>
827 <u>arrangement trust, as defined in subdivision (9) of subsection (a) of</u>
828 <u>section 1 of this act,</u> third-party administrator, as defined in section 38a-
829 720, or fraternal benefit society doing business in this state. Any such
830 examination may be conducted in accordance with the procedures and
831 definitions set forth in the National Association of Insurance

832 Commissioners' Market Regulation Handbook.

833 (b) To carry out the examinations under this section, the
834 commissioner may appoint, as market conduct examiners, one or more
835 competent persons, who shall not be officers of, or connected with or
836 interested in, any insurance company, health care center, multiple
837 employer welfare arrangement trust, third-party administrator or
838 fraternal benefit society, other than as a policyholder. In conducting the
839 examination, the commissioner, the commissioner's actuary or any
840 examiner authorized by the commissioner may examine, under oath,
841 the officers and agents of such insurance company, health care center,
842 multiple employer welfare arrangement trust, third-party administrator
843 or fraternal benefit society and all persons deemed to have material
844 information regarding the company's, center's, multiple employer
845 welfare arrangement trust's, administrator's or society's property or
846 business. Each such company, center, multiple employer welfare
847 arrangement trust, administrator or society, its officers and agents, shall
848 produce the books and papers, in its or their possession, relating to its
849 business or affairs, and any other person may be required to produce
850 any book or paper in such person's custody, deemed to be relevant to
851 the examination, for the inspection of the commissioner, the
852 commissioner's actuary or examiners, when required. The officers and
853 agents of the company, center, multiple employer welfare arrangement
854 trust, administrator or society shall facilitate the examination and aid
855 the examiners in making the same so far as it is in their power to do so.

856 (c) Each market conduct examiner shall make a full and true report
857 of each market conduct examination made by such examiner, which
858 shall comprise only facts appearing upon the books, papers, records or
859 documents of the examined company, center, multiple employer
860 welfare arrangement trust, administrator or society or ascertained from
861 the sworn testimony of its officers or agents or of other persons
862 examined under oath concerning its affairs. The examiner's report shall
863 be presumptive evidence of the facts therein stated in any action or
864 proceeding in the name of the state against the company, center,
865 multiple employer welfare arrangement trust, administrator or society,

866 its officers or agents. The commissioner shall grant a hearing to the
867 company, center, multiple employer welfare arrangement trust,
868 administrator or society examined before filing any such report and may
869 withhold any such report from public inspection for such time as the
870 commissioner deems proper. The commissioner may, if the
871 commissioner deems it in the public interest, publish any such report,
872 or the result of any such examination contained therein, in one or more
873 newspapers of the state.

874 (d) (1) All the expense of any examination made under the authority
875 of this section, other than examinations of domestic insurance
876 companies and domestic health care centers, shall be paid by the
877 company, center, multiple employer welfare arrangement trust,
878 administrator or society examined.

879 (2) No domestic insurance company or domestic health care center
880 subject to an examination under this section shall pay as costs associated
881 with the examination the salaries, fringe benefits or travel and
882 maintenance expenses of examining personnel of the Insurance
883 Department engaged in such examination if such domestic insurance
884 company or domestic health care center is otherwise liable to
885 assessment levied under section 38a-47, except that domestic insurance
886 companies and domestic health care centers examined outside the state
887 shall pay the travel and maintenance expenses of such examining
888 personnel.

889 (e) (1) No cause of action shall arise nor shall any liability be imposed
890 against the commissioner, the commissioner's authorized representative
891 or any examiner appointed or engaged by the commissioner for any
892 statements made or conduct performed in good faith while carrying out
893 the provisions of this section.

894 (2) No cause of action shall arise nor shall any liability be imposed
895 against any person for the act of communicating or delivering
896 information or data pursuant to an examination made under the
897 authority of this section to the commissioner, the commissioner's

898 authorized representative or an examiner if such communication or
899 delivery was performed in good faith and without fraudulent intent or
900 the intent to deceive.

901 (3) The provisions of this subsection shall not abrogate or modify any
902 common law or statutory privilege or immunity heretofore enjoyed by
903 any person identified in subdivision (1) of this subsection.

904 (f) Nothing in this section shall be construed to prevent or prohibit
905 the commissioner from disclosing at any time the content or results of
906 an examination report or a preliminary examination report or any
907 matter relating to such report, to (1) the insurance regulatory officials of
908 this state or any other state or country, (2) law enforcement officials of
909 this or any other state, or (3) any agency of this or any other state or of
910 the federal government, provided such officials or agency receiving the
911 report or matters relating to the report agrees, in writing, to hold such
912 report or matters confidential.

913 (g) All workpapers, recorded information, documents and copies
914 thereof produced by, obtained by or disclosed to the commissioner or
915 any other person in the course of an examination made under the
916 authority of this section shall be confidential, shall not be subject to
917 subpoena and shall not be made public by the commissioner or any
918 other person, except to the extent provided in subsection (f) of this
919 section. The commissioner may grant access to such workpapers,
920 recorded information, documents and copies to the National
921 Association of Insurance Commissioners, provided said association
922 agrees, in writing, to hold such workpapers, recorded information,
923 documents and copies thereof confidential.

924 Sec. 8. Subsection (a) of section 19a-755a of the general statutes is
925 repealed and the following is substituted in lieu thereof (*Effective October*
926 *1, 2023*):

927 (a) As used in this section:

928 (1) "All-payer claims database" means a database that receives and

929 stores data from a reporting entity relating to medical insurance claims,
930 dental insurance claims, pharmacy claims and other insurance claims
931 information from enrollment and eligibility files.

932 (2) (A) "Reporting entity" means:

933 (i) An insurer, as described in section 38a-1, licensed to do health
934 insurance business in this state;

935 (ii) A health care center, as defined in section 38a-175;

936 (iii) An insurer or health care center that provides coverage under
937 Part C or Part D of Title XVIII of the Social Security Act, as amended
938 from time to time, to residents of this state;

939 (iv) A third-party administrator, as defined in section 38a-720;

940 (v) A pharmacy benefits manager, as defined in section 38a-479aaa;

941 (vi) A hospital service corporation, as defined in section 38a-199;

942 (vii) A nonprofit medical service corporation, as defined in section
943 38a-214;

944 (viii) A fraternal benefit society, as described in section 38a-595, that
945 transacts health insurance business in this state;

946 (ix) A dental plan organization, as defined in section 38a-577;

947 (x) A preferred provider network, as defined in section 38a-479aa;
948 **[**and**]**

949 (xi) Any other person that administers health care claims and
950 payments pursuant to a contract or agreement or is required by statute
951 to administer such claims and payments; and

952 (xii) A multiple employer welfare arrangement trust, as defined in
953 subdivision (9) of subsection (a) of section 1 of this act.

954 (B) "Reporting entity" does not include an employee welfare benefit

955 plan, as defined in the federal Employee Retirement Income Security
956 Act of 1974, as amended from time to time, that is also a trust established
957 pursuant to collective bargaining subject to the federal Labor
958 Management Relations Act.

959 (3) "Medicaid data" means the Medicaid provider registry, health
960 claims data and Medicaid recipient data maintained by the Department
961 of Social Services.

962 (4) "CHIP data" means the provider registry, health claims data and
963 recipient data maintained by the Department of Social Services to
964 administer the Children's Health Insurance Program."

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	*April 1, 2024*	38a-567
Sec. 4	*from passage*	New section
Sec. 5	*October 1, 2023*	38a-9(a)
Sec. 6	*October 1, 2023*	38a-14
Sec. 7	*October 1, 2023*	38a-15
Sec. 8	*October 1, 2023*	19a-755a(a)