General Assembly

Amendment

February Session, 2024

LCO No. **4105**

Offered by:

SEN. HARDING, 30th Dist.
SEN. SAMPSON, 16th Dist.
SEN. CICARELLA, 34th Dist.
SEN. SOMERS, 18th Dist.
SEN. MARTIN, 31st Dist.
SEN. FAZIO, 36th Dist.
SEN. KELLY, 21st Dist.
SEN. BERTHEL, 32nd Dist.
SEN. KISSEL, 7th Dist.
SEN. GORDON, 35th Dist.
SEN. SEMINARA, 8th Dist.

To: Subst. Senate Bill No. **395** File No. 264 Cal. No. 190

"AN ACT CONCERNING THE REPORTING OF MEDICAL DEBT."

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

"Section 1. Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

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

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

(3) "Annuities" means all agreements to make periodical payments where the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life or is for a specified term of years. This definition does not apply to payments made under a policy of life insurance.

(4) "Commissioner" means the Insurance Commissioner.

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

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

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

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

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

(10) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and

surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not be limited to reserves required by statute or by regulations adopted by the commissioner in accordance with the provisions of chapter 54 or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

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

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

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

(14) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life. The business of life insurance includes granting endowment benefits, granting additional benefits in the event of death by accident or accidental means, granting additional benefits in the event of the total and permanent disability of the insured, and providing optional methods of settlement of proceeds.

Life insurance includes burial contracts to the extent provided by section 38a-464.

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

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

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

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

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

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

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

Sec. 2. (NEW) (*Effective October 1, 2024*) For the purposes of this section and section 3 of this act:

(1) "Actuarial value" means a level of coverage provided by a health plan design that is offered as a percentage of the full value of the benefits provided under such plan;

(2) "Commercial domicile" means the headquarters of a trade or business that is the place from which such trade or business is

principally managed and directed;

(3) "Employer member" means an entity domiciled in this state or that maintains such entity's commercial domicile in this state, is a member of a sponsoring association and employs more than one individual in this state. "Employer member" may include such employer member's sponsoring association, provided such sponsoring association is domiciled in this state and employs more than one individual in this state;

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

(5) "Health enhancement program" has the same meaning as provided in section 38a-477*ll* of the general statutes;

(6) "Multiple employer welfare arrangement health benefit plan" means any contract, certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state by a trust established by a sponsoring association in accordance with subsection (e) of section 3 of this act to provide, deliver, arrange for, pay for or reimburse any of the costs of the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. "Multiple employer welfare arrangement health benefit plan" does not include insurance products;

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

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

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

(10) "Self-funded multiple employer welfare arrangement" means a

program established or maintained on behalf of employer members and offered by a trust established by a sponsoring association in accordance with subsection (e) of section 3 of this act for the purpose of providing one or more multiple employer welfare arrangement health benefit plans for such employer member's employees and such employees' dependents;

(11) "Self-funded multiple employer welfare arrangement trust" means any trust established by a sponsoring association in accordance with subsection (e) of section 3 of this act;

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

(13) "Value-based health benefit plan design" means any material term in a multiple employer welfare arrangement health benefit plan that is designed to increase the quality of covered benefits or health care services while reducing the cost of such multiple employer welfare arrangement health benefit plan or health care services.

Sec. 3. (NEW) (*Effective October 1, 2024*) (a) No person, other than a self-funded multiple employer welfare arrangement trust, shall establish or operate a self-funded multiple employer welfare arrangement in this state.

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

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

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

(2) Beginning on April 1, 2025, any self-funded multiple employer welfare arrangement trust that meets the licensing requirements pursuant to subdivision (1) of this subsection and subsection (b) of this section may offer a multiple employer welfare arrangement health benefit plan to participating employees of one or more participating employers.

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

(1) 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 group state-mandated coverage requirements under chapter 700c of the general statutes;

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

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

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

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

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

(7) Utilize actuarially sound underwriting methodologies for pricing and renewing multiple employer welfare arrangement health benefit plans for participating employers;

(8) Adopt and maintain underwriting guidelines for evaluating applicants and accepting such applicants as new participating employers;

(9) Adopt and maintain renewal methodologies, which may be reviewed by the commissioner;

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

(11) Make any multiple employer welfare arrangement health benefit plan available to all participating employers regardless of any factor relating to the health status of such participating employer or

individuals eligible for coverage through any participating employer;

(12) (A) Implement value-based health benefit plan design and value-based contracting by administering programs, which may include, but need not be limited to, centers of excellence, wellness programs, health enhancement programs, alternative payment models, chronic disease navigation and patient-centered medical homes. (B) Beginning on August 1, 2025, each self-funded multiple employer welfare arrangement trust shall annually report, on a form provided by the Insurance Commissioner, such implementation of value-based health benefit plan design and value-based contracting pursuant to this subdivision. Such report to the Insurance Commissioner shall include the following: (i) A description of such value-based health benefit plan design and value-based contracting programs; (ii) the number of participating employees enrolled in such value-based health benefit plan design and value-based contracting programs; (iii) the percentage of dollars spent on such value-based health benefit plan design and value-based contracting programs; and (iv) a description that explains how such value-based health benefit plan design and value-based contracting programs lower costs for participating employees enrolled in such programs; and

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

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

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

(2) A Form M-1 shall be filed each year by such trust 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 the self-funded multiple employer welfare arrangement trust; and (B) a description of the multiple employer welfare arrangement health benefit plans offered through such self-funded multiple employer welfare arrangement trust;

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

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

(B) State that the purpose of such self-funded multiple employer welfare arrangement trust is to provide multiple employer welfare arrangement health benefit plans to eligible employers;

(C) Provide that self-funded multiple employer welfare arrangement trust funds shall be used for the benefit of eligible employers 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 self-funded multiple employer welfare arrangement trust and any multiple employer welfare arrangement health benefit plan issued by such trust;

(D) Limit participation in any multiple employer welfare arrangement health benefit plan to eligible employers;

(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 trust for the purpose of managing all multiple employer welfare arrangement health benefit plans established, maintained and offered by such self-funded multiple employer welfare arrangement trust. Any board of trustees shall have the authority to contract with any licensed administrator or service company to administer the daily operations of the multiple employer welfare arrangement health benefit plans;

(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;

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

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

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

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

(8) The self-funded multiple employer welfare arrangement trust shall purchase and maintain commercially reasonable directors' and officers' liability insurance from insurers licensed to transact the business of insurance in this state;

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

(10) No self-funded multiple employer welfare arrangement 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 indicates that such self-funded multiple employer welfare arrangement trust is not an insurance company and is not transacting the business of insurance.

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

(1) Operate any multiple employer welfare arrangement health benefit plan in accordance with the fiduciary standards set forth in the Consolidated Appropriations Act of 2021, P.L. 116-260, as amended from time to time, and all other generally accepted fiduciary standards;

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

under section 38a-48 of the general statutes, or (D) the premium tax required under section 12-202 of the general statutes.

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

(h) Multiple employer welfare arrangement health benefit plan documents issued by any self-funded multiple employer welfare arrangement trust to participating employers shall have the following statement printed on the first page in fourteen-point boldface type: "This multiple employer welfare arrangement health benefit plan is provided by a trust established to provide multiple employer welfare arrangement health benefit plans to employees of employers participating in a self-funded multiple employer welfare arrangement. This multiple employer welfare arrangement health benefit plan is not insurance and is not offered through an insurance company. This multiple employer welfare arrangement health benefit plan 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 participating employer shall be liable for such participating employer's allocated share of the liabilities of the trust under all multiple employer welfare arrangement health benefit plans offered by the trust, as determined by the board of trustees. Each participating employer shall be jointly and severally liable for additional amounts if the annual multiple employer welfare arrangement health benefit plan subscription amounts paid by all participating employers and participating employees of such participating employer result in a

deficit of funds for the trust and for any assessments by state regulators. The trust's financial statements shall be made available upon request by any participating employer in the self-funded multiple employer welfare arrangement.".

(i) Multiple employer welfare arrangement health benefit plan documents issued by any self-funded multiple employer welfare arrangement trust to participating employees shall have the following statement printed on the first page in fourteen-point boldface type: "This multiple employer welfare arrangement health benefit plan is provided by a trust established to provide multiple employer welfare arrangement health benefit plans to employees of employers participating in a self-funded multiple employer welfare arrangement, including your employer. This multiple employer welfare arrangement health benefit plan is not insurance and is not offered through an insurance company. This multiple employer welfare arrangement health benefit plan 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. Your employer shall be liable for such employer's allocated share of the liabilities of the trust under all multiple employer welfare arrangement health benefit plans offered by the trust, as determined by the board of trustees. Your employer shall be jointly and severally liable for additional amounts if the annual multiple employer welfare arrangement health benefit plan subscription amounts paid by all participating employers and participating employees of such participating employer result in a deficit of funds for the trust and for any assessments by state regulators. The trust's financial statements shall be made available to you upon request. The Consumer Affairs Division within the Insurance Department is available to assist you with questions that you may have concerning this multiple employer welfare arrangement health benefit plan.". The notice shall include the telephone number and electronic mail address for the Consumer Affairs Division.

(j) No self-funded multiple employer welfare arrangement trust shall be subject to the Connecticut Insurance Guaranty Association pursuant

to sections 38a-836 to 38a-853, inclusive, of the general statutes.

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

Sec. 4. Section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective April 1, 2025*):

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, except as a member of an association of 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, except as a member of an association of 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.

Sec. 5. Subsection (a) of section 38a-9 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) Notwithstanding the provisions of section 4-8, there shall be a Division of Consumer Affairs within the Insurance Department, which division shall act on the Insurance Commissioner's behalf and at his direction in order to carry out his responsibilities under this title with respect to such matters. The division shall receive and review complaints from residents of this state concerning their insurance problems and problems arising out of multiple employer welfare arrangement health benefit plans, as defined in section 2 of this act, including claims disputes, and serve as a mediator in such disputes in order to assist the commissioner in determining whether statutory requirements and contractual obligations within the commissioner's jurisdiction have been fulfilled. There shall be a director of said division, who shall be provided with sufficient staff. The division shall serve to coordinate all appropriate facilities in the department in addressing such complaints, and conduct any outreach programs deemed necessary to properly inform and educate the public on insurance matters. The director shall submit quarterly reports to the commissioner, which shall state the number of complaints received by the division in such calendar quarter, the Connecticut premium or premium equivalent volume of the appropriate line of each insurance company or multiple employer welfare arrangement trust, as defined in section 2 of this act, against which a complaint has been filed, the types of complaints received, and the number of such complaints which have been resolved. Such reports shall be published every six months and copies shall be made available to any interested resident of this state upon request. The commissioner shall report, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance on or before January

fifteenth annually, concerning the findings of such reports and suggestions for legislative initiatives to address recurring problems.

Sec. 6. Section 38a-14 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) For the purposes of this section, "company" means any insurance company, multiple employer welfare arrangement trust, as defined in section 2 of this act, or health care center doing business in this state, any corporation or association collecting data utilized by any such insurance company in the underwriting of insurance policies and any corporation organized under any law of this state or having an office in this state, which corporation is engaged in, or claiming or advertising that it is engaged in, organizing or receiving subscriptions for or disposing of stock of, or in any manner aiding or taking part in the formation or business of, an insurance company or companies, or that is holding the capital stock of one or more insurance corporations for the purpose of controlling the management thereof, as voting trustees or otherwise.

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

(c) (1) To carry out examinations under this section, the commissioner may appoint one or more competent persons as examiners, who shall not be officers of, connected with or interested in any company, other than as policyholders. The commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners to assist the commissioner in conducting the examinations under this

section, the cost of which shall be borne by the company that is the subject of the examination.

(2) In conducting the examination, the commissioner, the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such a company, and all persons deemed to have material information regarding the company's property or business. Each such company or its officers and agents shall produce the books and papers in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper in such person's custody that is deemed to be relevant to such examination, for inspection by the commissioner, the commissioner's actuary or examiners. The officers and agents of the company shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension of, refusal of or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to subsection (c) of section 38a-41.

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

(d) In lieu of an examination under this section of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on such insurer prepared by the insurance department for the insurer's state of domicile or port-of-entry state if (1) such state's insurance department was, at the time of the examination, accredited under the National Association of Insurance Commissioners'

financial regulation standards and accreditation program, or (2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

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

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

(3) Not later than sixty days following completion of the examination, the examiner in charge shall file, under oath, with the Insurance Department a verified written report of examination. Upon receipt of the verified report, the Insurance Department shall transmit the report to the company examined, together with a notice that shall afford the company examined a reasonable opportunity, not to exceed thirty days, to make a written submission or rebuttal with respect to any matters contained in the examination report. Not later than thirty days after the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order: (A) Adopting the examination report as filed or with modification or corrections. If the

examination report reveals that the company is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation; (B) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to this subdivision; or (C) calling for an investigatory hearing with not less than twenty days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

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

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

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

(2) Any investigatory hearing conducted under subparagraph (C) of

subdivision (3) of subsection (e) of this section by the commissioner or the commissioner's authorized representative, shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent (A) upon the filed examination report, (B) raised by or as a result of the commissioner's review of relevant workpapers, or (C) by the written submission or rebuttal of the company. Not later than twenty days after the conclusion of any such hearing, the commissioner shall enter an order pursuant to subparagraph (A) of subdivision (3) of subsection (e) of this section. The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's authorized representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation, whether under the control of the department, the company or other persons. The documents produced shall be included in the record and testimony taken by the commissioner or the commissioner's authorized representative shall be under oath and preserved for the record. Nothing contained in this section shall require the department to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency. The hearing shall proceed with the commissioner or the commissioner's authorized representative posing questions to the persons subpoenaed. Thereafter, the company and the Insurance Department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the commissioner or the commissioner's authorized representative. The company and the Insurance Department shall be permitted to make closing statements and may be represented by counsel of their choice.

(g) The commissioner may, if the commissioner deems it in the public interest, publish any such report, or the result of any such examination

contained therein, in one or more newspapers of the state.

(h) The commissioner shall, at least once in every five years, visit and examine the affairs of each domestic insurer, domestic health care center, domestic fraternal benefit society, multiple employer welfare arrangement trust, as defined in section 2 of this act and foreign and alien insurer doing business in this state. Notwithstanding subdivision (1) of subsection (c) of this section, no domestic insurer or such other domestic entity subject to examination under this section shall pay as costs associated with the examination the salaries, fringe benefits or travel and maintenance expenses of examining personnel of the Insurance Department engaged in such examination if such domestic insurer or domestic entity is otherwise liable to assessment levied under section 38a-47, except that a domestic insurer or such other domestic entity shall pay the travel and maintenance expenses of examining personnel of the Insurance Department when such insurer or entity is examined outside the state.

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

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

such workpapers, recorded information, documents and copies thereof confidential.

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

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

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

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

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

Sec. 7. Section 38a-15 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) The commissioner shall, as often as the commissioner deems it expedient, undertake a market conduct examination of the affairs of any insurance company, health care center, multiple employer welfare arrangement trust, as defined in section 2 of this act, third-party administrator, as defined in section 38a-720, or fraternal benefit society doing business in this state. Any such examination may be conducted in accordance with the procedures and definitions set forth in the National Association of Insurance Commissioners' Market Regulation Handbook.

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

(c) Each market conduct examiner shall make a full and true report of each market conduct examination made by such examiner, which shall comprise only facts appearing upon the books, papers, records or documents of the examined company, center, multiple employer welfare arrangement trust, administrator or society or ascertained from the sworn testimony of its officers or agents or of other persons examined under oath concerning its affairs. The examiner's report shall be presumptive evidence of the facts therein stated in any action or proceeding in the name of the state against the company, center, multiple employer welfare arrangement trust, administrator or society, its officers or agents. The commissioner shall grant a hearing to the company, center, multiple employer welfare arrangement trust, administrator or society examined before filing any such report and may withhold any such report from public inspection for such time as the commissioner deems proper. The commissioner may, if the commissioner deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

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

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

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

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

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

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

(g) All workpapers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under the authority of this section shall be confidential, shall not be subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subsection (f) of this section. The commissioner may grant access to such workpapers, recorded information, documents and copies to the National

Association of Insurance Commissioners, provided said association agrees, in writing, to hold such workpapers, recorded information, documents and copies thereof confidential.

Sec. 8. Subsection (a) of section 19a-755a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) As used in this section:

(1) "All-payer claims database" means a database that receives and stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files.

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

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

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

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

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

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

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

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

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

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

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

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

(xii) A multiple employer welfare arrangement trust, as defined in section 2 of this act.

(B) "Reporting entity" does not include an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2024*	38a-1
Sec. 2	*October 1, 2024*	New section
Sec. 3	*October 1, 2024*	New section
Sec. 4	*April 1, 2025*	38a-567
Sec. 5	*October 1, 2024*	38a-9(a)
Sec. 6	*October 1, 2024*	38a-14
Sec. 7	*October 1, 2024*	38a-15
Sec. 8	*October 1, 2024*	19a-755a(a)