



General Assembly

**Amendment**

February Session, 2024

LCO No. 4940



Offered by:

SEN. HARDING, 30<sup>th</sup> Dist.

SEN. SAMPSON, 16<sup>th</sup> Dist.

SEN. MARTIN, 31<sup>st</sup> Dist.

SEN. KELLY, 21<sup>st</sup> Dist.

SEN. FAZIO, 36<sup>th</sup> Dist.

SEN. SEMINARA, 8<sup>th</sup> Dist.

SEN. HWANG, 28<sup>th</sup> Dist.

To: Subst. Senate Bill No. 8

File No. 309

Cal. No. 197

**"AN ACT CONCERNING DRUG AFFORDABILITY."**

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

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 Section 38a-1 of the general statutes is repealed and the  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

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

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

11 (2) "Alien insurer" means any insurer that has been chartered by or  
12 organized or constituted within or under the laws of any jurisdiction or

13 country without the United States.

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

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

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

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

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

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

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

38 (10) "Insolvency" or "insolvent" means, for any insurer, that it is  
39 unable to pay its obligations when they are due, or when its admitted  
40 assets do not exceed its liabilities plus the greater of: (A) Capital and  
41 surplus required by law for its organization and continued operation;  
42 or (B) the total par or stated value of its authorized and issued capital

43 stock. For purposes of this subdivision "liabilities" shall include but not  
44 be limited to reserves required by statute or by regulations adopted by  
45 the commissioner in accordance with the provisions of chapter 54 or  
46 specific requirements imposed by the commissioner upon a subject  
47 company at the time of admission or subsequent thereto.

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

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

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

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

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

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

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

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

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

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

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

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

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

99 (2) "Commercial domicile" means the headquarters of a trade or  
100 business that is the place from which such trade or business is  
101 principally managed and directed;

102 (3) "Employer member" means an entity domiciled in this state or that

103 maintains such entity's commercial domicile in this state, is a member  
104 of a sponsoring association and employs more than one individual in  
105 this state. "Employer member" may include such employer member's  
106 sponsoring association, provided such sponsoring association is  
107 domiciled in this state and employs more than one individual in this  
108 state;

109 (4) "ERISA" means the Employee Retirement Income Security Act of  
110 1974, as amended from time to time;

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

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

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

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

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

130 (10) "Self-funded multiple employer welfare arrangement" means a  
131 program established or maintained on behalf of employer members and  
132 offered by a trust established by a sponsoring association in accordance

133 with subsection (e) of section 3 of this act for the purpose of providing  
134 one or more multiple employer welfare arrangement health benefit  
135 plans for such employer member's employees and such employees'  
136 dependents;

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

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

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

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

156 (b) Any self-funded multiple employer welfare arrangement trust,  
157 prior to establishing a self-funded multiple employer welfare  
158 arrangement in this state, shall apply for and obtain a license from the  
159 commissioner. The commissioner shall issue a license to such self-  
160 funded multiple employer welfare arrangement trust, provided such  
161 trust satisfies all licensing requirements applicable to a health insurance  
162 company pursuant to chapter 698 of the general statutes. Upon the  
163 issuance of a license by the commissioner to a self-funded multiple  
164 employer welfare arrangement trust, in accordance with the provisions

165 of this subsection, such trust shall comply with all requirements  
166 applicable to health insurance companies set forth in title 38a of the  
167 general statutes, and any regulations adopted by the commissioner, in  
168 accordance with the provisions of chapter 54 of the general statutes.

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

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

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

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

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

195 (3) Not limit or exclude coverage for any individual by imposing a

196 preexisting conditions provision on such individual;

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

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

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

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

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

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

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

222 (11) Make any multiple employer welfare arrangement health benefit  
223 plan available to all participating employers regardless of any factor  
224 relating to the health status of such participating employer or  
225 individuals eligible for coverage through any participating employer;



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

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

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

257 (1) The self-funded multiple employer welfare arrangement trust  
258 shall be subject to ERISA and any regulations or standards prescribed

259 by the United States Department of Labor pertaining to multiple  
260 employer welfare arrangements;

261 (2) A Form M-1 shall be filed each year by such trust with the United  
262 States Department of Labor. For purposes of this subdivision, "Form M-  
263 1" means an annual report required by the United States Department of  
264 Labor for multiple employer welfare arrangements that includes, but is  
265 not limited to, the following: (A) Identification of the sponsoring  
266 association and the self-funded multiple employer welfare arrangement  
267 trust; and (B) a description of the multiple employer welfare  
268 arrangement health benefit plans offered through such self-funded  
269 multiple employer welfare arrangement trust;

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

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

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

277 (C) Provide that self-funded multiple employer welfare arrangement  
278 trust funds shall be used for the benefit of eligible employers through (i)  
279 self-funding of claims or the purchase of reinsurance, or any  
280 combination thereof, and (ii) defraying the costs and expenses of  
281 administering and operating such self-funded multiple employer  
282 welfare arrangement trust and any multiple employer welfare  
283 arrangement health benefit plan issued by such trust;

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

286 (E) Establish and maintain a board of trustees, composed of not less  
287 than five trustees, that shall have fiscal control over such self-funded  
288 multiple employer welfare arrangement trust for the purpose of

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

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

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

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

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

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

319 (7) The self-funded multiple employer welfare arrangement trust

320 shall purchase and maintain commercially reasonable fiduciary liability  
321 insurance from insurers licensed to transact the business of insurance in  
322 this state;

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

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

330 (10) No self-funded multiple employer welfare arrangement trust  
331 shall include in its name the words "insurance", "insurer", "underwriter",  
332 "mutual" or any other word or term or combination of words or terms  
333 that is descriptive of an insurance company or insurance business,  
334 unless the context of such words or terms indicates that such self-funded  
335 multiple employer welfare arrangement trust is not an insurance  
336 company and is not transacting the business of insurance.

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

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

343 (2) Pay all costs assessed by the commissioner in accordance with title  
344 38a of the general statutes. Such board of trustees shall have the  
345 authority to collect fees on a pro rata basis from the participating  
346 employers. No self-funded multiple employer welfare arrangement  
347 trust shall be subject to (A) the health and welfare fee required under  
348 section 19a-7j of the general statutes, (B) the public health fee required  
349 under section 19a-7p of the general statutes, (C) any payment required  
350 under section 38a-48 of the general statutes, or (D) the premium tax

351 required under section 12-202 of the general statutes.

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

363 (h) Multiple employer welfare arrangement health benefit plan  
364 documents issued by any self-funded multiple employer welfare  
365 arrangement trust to participating employers shall have the following  
366 statement printed on the first page in fourteen-point boldface type: "This  
367 multiple employer welfare arrangement health benefit plan is provided  
368 by a trust established to provide multiple employer welfare  
369 arrangement health benefit plans to employees of employers  
370 participating in a self-funded multiple employer welfare arrangement.  
371 This multiple employer welfare arrangement health benefit plan is not  
372 insurance and is not offered through an insurance company. This  
373 multiple employer welfare arrangement health benefit plan is not  
374 required to comply with certain federal market requirements for health  
375 insurance, and is not required to comply with certain state laws for  
376 health insurance. Each participating employer shall be liable for such  
377 participating employer's allocated share of the liabilities of the trust  
378 under all multiple employer welfare arrangement health benefit plans  
379 offered by the trust, as determined by the board of trustees. Each  
380 participating employer shall be jointly and severally liable for additional  
381 amounts if the annual multiple employer welfare arrangement health  
382 benefit plan subscription amounts paid by all participating employers  
383 and participating employees of such participating employer result in a  
384 deficit of funds for the trust and for any assessments by state regulators.

385 The trust's financial statements shall be made available upon request by  
386 any participating employer in the self-funded multiple employer  
387 welfare arrangement."

388 (i) Multiple employer welfare arrangement health benefit plan  
389 documents issued by any self-funded multiple employer welfare  
390 arrangement trust to participating employees shall have the following  
391 statement printed on the first page in fourteen-point boldface type: "This  
392 multiple employer welfare arrangement health benefit plan is provided  
393 by a trust established to provide multiple employer welfare  
394 arrangement health benefit plans to employees of employers  
395 participating in a self-funded multiple employer welfare arrangement,  
396 including your employer. This multiple employer welfare arrangement  
397 health benefit plan is not insurance and is not offered through an  
398 insurance company. This multiple employer welfare arrangement  
399 health benefit plan is not required to comply with certain federal market  
400 requirements for health insurance, and is not required to comply with  
401 certain state laws for health insurance. Your employer shall be liable for  
402 such employer's allocated share of the liabilities of the trust under all  
403 multiple employer welfare arrangement health benefit plans offered by  
404 the trust, as determined by the board of trustees. Your employer shall  
405 be jointly and severally liable for additional amounts if the annual  
406 multiple employer welfare arrangement health benefit plan  
407 subscription amounts paid by all participating employers and  
408 participating employees of such participating employer result in a  
409 deficit of funds for the trust and for any assessments by state regulators.  
410 The trust's financial statements shall be made available to you upon  
411 request. The Consumer Affairs Division within the Insurance  
412 Department is available to assist you with questions that you may have  
413 concerning this multiple employer welfare arrangement health benefit  
414 plan.". The notice shall include the telephone number and electronic  
415 mail address for the Consumer Affairs Division.

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

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

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

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

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

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

446 (C) Renewability of coverage may be effected by either continuing in  
447 effect a plan or arrangement covering a small employer or by  
448 substituting upon renewal for the prior plan or arrangement the plan or  
449 arrangement then offered by the carrier that most closely corresponds  
450 to the prior plan or arrangement and is available to other small

451 employers. Such substitution shall only be made under conditions  
452 approved by the commissioner. A carrier may substitute a plan or  
453 arrangement as set forth in this subparagraph only if the carrier effects  
454 the same substitution upon renewal for all small employers previously  
455 covered under the particular plan or arrangement, unless otherwise  
456 approved by the commissioner. The substitute plan or arrangement  
457 shall be subject to the rating restrictions specified in this section on the  
458 same basis as if no substitution had occurred, except for an adjustment  
459 based on coverage differences.

460 (D) Any such plan or arrangement shall provide special enrollment  
461 periods (i) to all eligible employees or dependents as set forth in 45 CFR  
462 147.104, as amended from time to time, and (ii) for coverage under such  
463 plan or arrangement ordered by a court for a spouse or minor child of  
464 an eligible employee where request for enrollment is made not later than  
465 thirty days after the issuance of such court order.

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

470 (B) With respect to grandfathered plans issued to small employers,  
471 except as a member of an association of small employers, the premium  
472 rates charged or offered shall be established on the basis of a single pool  
473 of all grandfathered plans, adjusted to reflect one or more of the  
474 following classifications:

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

477 (ii) Gender;

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

480 (iv) Industry, provided the rate factor associated with any industry



481 classification shall not vary from the arithmetic average of the highest  
482 and lowest rate factors associated with all industry classifications by  
483 greater than fifteen per cent of such average, and provided further, the  
484 rate factors associated with any industry shall not be increased by more  
485 than five per cent per year;

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

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

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

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

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

511 (I) Age, in accordance with a uniform age rating curve established by

512 the commissioner; or

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

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

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

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

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

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

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

541 (4) No small employer carrier shall, directly or indirectly, enter into

542 any contract, agreement or arrangement with a producer that provides  
543 for or results in the compensation paid to a producer for the sale of a  
544 health benefit plan to be varied because of the health status, claims  
545 experience, industry, occupation or geographic area of the small  
546 employer. A small employer carrier shall provide reasonable  
547 compensation, as provided under the plan of operation of the program,  
548 to a producer, if any, for the sale of a health care plan. No small  
549 employer carrier shall terminate, fail to renew or limit its contract or  
550 agreement of representation with a producer for any reason related to  
551 the health status, claims experience, occupation, or geographic location  
552 of the small employers placed by the producer with the small employer  
553 carrier.

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

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

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

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

572 (9) Any violation of subdivisions (3) to (7), inclusive, of this section  
573 and of any regulations established under subdivision (8) of this section

574 shall be an unfair and prohibited practice under sections 38a-815 to 38a-  
575 830, inclusive.

576 Sec. 5. Subsection (a) of section 38a-9 of the general statutes is  
577 repealed and the following is substituted in lieu thereof (*Effective October*  
578 *1, 2024*):

579 (a) Notwithstanding the provisions of section 4-8, there shall be a  
580 Division of Consumer Affairs within the Insurance Department, which  
581 division shall act on the Insurance Commissioner's behalf and at his  
582 direction in order to carry out his responsibilities under this title with  
583 respect to such matters. The division shall receive and review  
584 complaints from residents of this state concerning their insurance  
585 problems and problems arising out of multiple employer welfare  
586 arrangement health benefit plans, as defined in section 2 of this act,  
587 including claims disputes, and serve as a mediator in such disputes in  
588 order to assist the commissioner in determining whether statutory  
589 requirements and contractual obligations within the commissioner's  
590 jurisdiction have been fulfilled. There shall be a director of said division,  
591 who shall be provided with sufficient staff. The division shall serve to  
592 coordinate all appropriate facilities in the department in addressing  
593 such complaints, and conduct any outreach programs deemed  
594 necessary to properly inform and educate the public on insurance  
595 matters. The director shall submit quarterly reports to the  
596 commissioner, which shall state the number of complaints received by  
597 the division in such calendar quarter, the Connecticut premium or  
598 premium equivalent volume of the appropriate line of each insurance  
599 company or multiple employer welfare arrangement trust, as defined in  
600 section 2 of this act, against which a complaint has been filed, the types  
601 of complaints received, and the number of such complaints which have  
602 been resolved. Such reports shall be published every six months and  
603 copies shall be made available to any interested resident of this state  
604 upon request. The commissioner shall report, in accordance with section  
605 11-4a, to the joint standing committee of the General Assembly having  
606 cognizance of matters relating to insurance on or before January  
607 fifteenth annually, concerning the findings of such reports and

608 suggestions for legislative initiatives to address recurring problems.

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

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

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

632 (c) (1) To carry out examinations under this section, the commissioner  
633 may appoint one or more competent persons as examiners, who shall  
634 not be officers of, connected with or interested in any company, other  
635 than as policyholders. The commissioner may engage the services of  
636 attorneys, appraisers, independent actuaries, independent certified  
637 public accountants or other professionals and specialists as examiners  
638 to assist the commissioner in conducting the examinations under this  
639 section, the cost of which shall be borne by the company that is the

640 subject of the examination.

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

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

666 (d) In lieu of an examination under this section of any foreign or alien  
667 insurer licensed in this state, the commissioner may accept an  
668 examination report on such insurer prepared by the insurance  
669 department for the insurer's state of domicile or port-of-entry state if (1)  
670 such state's insurance department was, at the time of the examination,  
671 accredited under the National Association of Insurance Commissioners'  
672 financial regulation standards and accreditation program, or (2) the

673 examination is performed under the supervision of an accredited  
674 insurance department or with the participation of one or more  
675 examiners who are employed by such an accredited state insurance  
676 department and who, after a review of the examination workpapers and  
677 report, state under oath that the examination was performed in a  
678 manner consistent with the standards and procedures required by their  
679 insurance department.

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

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

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

706 any law, regulation or prior order of the commissioner, the  
707 commissioner may order the company to take any action the  
708 commissioner considers necessary and appropriate to cure such  
709 violation; (B) rejecting the examination report with directions to the  
710 examiners to reopen the examination for purposes of obtaining  
711 additional data, documentation or information, and refile pursuant to  
712 this subdivision; or (C) calling for an investigatory hearing with not less  
713 than twenty days' notice to the company for purposes of obtaining  
714 additional documentation, data, information and testimony.

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

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

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

736 (2) Any investigatory hearing conducted under subparagraph (C) of  
737 subdivision (3) of subsection (e) of this section by the commissioner or



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

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

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

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

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

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

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

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

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

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

834 Sec. 7. Section 38a-15 of the general statutes is repealed and the  
835 following is substituted in lieu thereof (*Effective October 1, 2024*):

836 (a) The commissioner shall, as often as the commissioner deems it

837 expedient, undertake a market conduct examination of the affairs of any  
838 insurance company, health care center, multiple employer welfare  
839 arrangement trust, as defined in section 2 of this act, third-party  
840 administrator, as defined in section 38a-720, or fraternal benefit society  
841 doing business in this state. Any such examination may be conducted in  
842 accordance with the procedures and definitions set forth in the National  
843 Association of Insurance Commissioners' Market Regulation  
844 Handbook.

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

868 (c) Each market conduct examiner shall make a full and true report  
869 of each market conduct examination made by such examiner, which  
870 shall comprise only facts appearing upon the books, papers, records or

871 documents of the examined company, center, multiple employer  
872 welfare arrangement trust, administrator or society or ascertained from  
873 the sworn testimony of its officers or agents or of other persons  
874 examined under oath concerning its affairs. The examiner's report shall  
875 be presumptive evidence of the facts therein stated in any action or  
876 proceeding in the name of the state against the company, center,  
877 multiple employer welfare arrangement trust, administrator or society,  
878 its officers or agents. The commissioner shall grant a hearing to the  
879 company, center, multiple employer welfare arrangement trust,  
880 administrator or society examined before filing any such report and may  
881 withhold any such report from public inspection for such time as the  
882 commissioner deems proper. The commissioner may, if the  
883 commissioner deems it in the public interest, publish any such report,  
884 or the result of any such examination contained therein, in one or more  
885 newspapers of the state.

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

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

901 (e) (1) No cause of action shall arise nor shall any liability be imposed  
902 against the commissioner, the commissioner's authorized representative  
903 or any examiner appointed or engaged by the commissioner for any

904 statements made or conduct performed in good faith while carrying out  
905 the provisions of this section.

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

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

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

925 (g) All workpapers, recorded information, documents and copies  
926 thereof produced by, obtained by or disclosed to the commissioner or  
927 any other person in the course of an examination made under the  
928 authority of this section shall be confidential, shall not be subject to  
929 subpoena and shall not be made public by the commissioner or any  
930 other person, except to the extent provided in subsection (f) of this  
931 section. The commissioner may grant access to such workpapers,  
932 recorded information, documents and copies to the National  
933 Association of Insurance Commissioners, provided said association  
934 agrees, in writing, to hold such workpapers, recorded information,  
935 documents and copies thereof confidential.

936 Sec. 8. Subsection (a) of section 19a-755a of the general statutes is  
937 repealed and the following is substituted in lieu thereof (*Effective October*  
938 *1, 2024*):

939 (a) As used in this section:

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

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

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

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

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

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

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

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

954 (vii) A nonprofit medical service corporation, as defined in section  
955 38a-214;

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

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

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

961 (xi) Any other person that administers health care claims and

962 payments pursuant to a contract or agreement or is required by statute  
 963 to administer such claims and payments; and

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

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

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

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

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