



General Assembly

Amendment

February Session, 2024

LCO No. 4233



Offered by:
SEN. SAMPSON, 16th Dist.

To: Senate Bill No. 180

File No. 18

Cal. No. 43

"AN ACT CONCERNING ADVERSE DETERMINATION AND UTILIZATION REVIEWS."

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 Section 38a-1 of the general statutes is repealed and the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	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)