



General Assembly

Amendment

January Session, 2025

LCO No. 7682



Offered by:

SEN. HARDING, 30th Dist.
SEN. MARTIN, 31st Dist.
SEN. SAMPSON, 16th Dist.
SEN. CICARELLA, 34th Dist.
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SEN. HWANG, 28th Dist.

SEN. BERTHEL, 32nd Dist.
SEN. FAZIO, 36th Dist.
SEN. GORDON, 35th Dist.
SEN. KISSEL, 7th Dist.
SEN. PERILLO J., 21st Dist.

To: Senate Bill No. 1384

File No. 379

Cal. No. 230

"AN ACT ALLOWING BOARD MEMBERS OF QUASI-PUBLIC AGENCIES TO OBTAIN HEALTH INSURANCE COVERAGE UNDER THE STATE EMPLOYEE PLAN."

1 After the last section, add the following and renumber sections and
2 internal references accordingly:

3 "Sec. 501. Section 38a-1 of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective October 1, 2025*):

5 Terms used in this title, and sections 502 and 503 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. 502. (NEW) (*Effective October 1, 2025*) For the purposes of this
95 section and section 503 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 benefit plan" means a contract, certificate or agreement
112 offered, delivered, issued for delivery, renewed, amended or continued
113 in this state by a self-funded multiple employer welfare arrangement
114 trust to provide, deliver, arrange for, pay for or reimburse any of the
115 costs of the diagnosis, prevention, treatment, cure or relief of a health
116 condition, illness, injury or disease. "Health benefit plan" does not
117 include insurance products;

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

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

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

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

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

128 program established or maintained on behalf of employer members and
129 offered by a self-funded multiple employer welfare arrangement trust
130 for the purpose of providing one or more health benefit plans for such
131 employer member's employees and such employees' dependents;

132 (11) "Self-funded multiple employer welfare arrangement trust"
133 means any trust established by a sponsoring association in accordance
134 with subsection (e) of section 503 of this act;

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

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

146 Sec. 503. (NEW) (*Effective October 1, 2025*) (a) No person, other than a
147 self-funded multiple employer welfare arrangement trust, shall
148 establish or operate a self-funded multiple employer welfare
149 arrangement in this state.

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

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

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

167 (2) Beginning on April 1, 2026, any self-funded multiple employer
168 welfare arrangement trust that meets the licensing requirements
169 pursuant to subdivision (1) of this subsection and subsection (b) of this
170 section may offer a health benefit plan to participating employees of one
171 or more participating employers.

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

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

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

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

188 (4) Not establish discriminatory rules based on the health status of an

189 individual related to health benefit plan eligibility, or rate or
190 contribution requirements;

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

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

201 (7) Utilize actuarially sound underwriting methodologies for pricing
202 and renewing health benefit plans for participating employers;

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

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

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

212 (11) Make any health benefit plan available to all participating
213 employers regardless of any factor relating to the health status of such
214 participating employer or individuals eligible for coverage through any
215 participating employer;

216 (12) (A) Implement value-based health benefit plan design and value-
217 based contracting by administering programs, which may include, but

218 need not be limited to, centers of excellence, wellness programs, health
219 enhancement programs, alternative payment models, chronic disease
220 navigation and patient-centered medical homes. (B) Beginning on
221 August 1, 2026, each self-funded multiple employer welfare
222 arrangement trust shall annually report, on a form provided by the
223 Insurance Commissioner, such implementation of value-based health
224 benefit plan design and value-based contracting pursuant to this
225 subdivision. Such report to the Insurance Commissioner shall include
226 the following: (i) A description of such value-based health benefit plan
227 design and value-based contracting programs; (ii) the number of
228 participating employees enrolled in such value-based health benefit
229 plan design and value-based contracting programs; (iii) the percentage
230 of dollars spent on such value-based health benefit plan design and
231 value-based contracting programs; and (iv) a description that explains
232 how such value-based health benefit plan design and value-based
233 contracting programs lower costs for participating employees enrolled
234 in such programs; and

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

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

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

250 (2) A Form M-1 shall be filed each year by such trust with the United
251 States Department of Labor. For purposes of this subdivision, "Form M-
252 1" means an annual report required by the United States Department of
253 Labor for multiple employer welfare arrangements that includes, but is
254 not limited to, the following: (A) Identification of the sponsoring
255 association and the self-funded multiple employer welfare arrangement
256 trust; and (B) a description of the health benefit plans offered through
257 such self-funded multiple employer welfare arrangement trust;

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

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

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

265 (C) Provide that self-funded multiple employer welfare arrangement
266 trust funds shall be used for the benefit of eligible employers through (i)
267 self-funding of claims or the purchase of reinsurance, or any
268 combination thereof, and (ii) defraying the costs and expenses of
269 administering and operating such self-funded multiple employer
270 welfare arrangement trust and any health benefit plan issued by such
271 trust;

272 (D) Limit participation in any health benefit plan to eligible
273 employers;

274 (E) Establish and maintain a board of trustees, composed of not less
275 than five trustees, that shall have fiscal control over such self-funded
276 multiple employer welfare arrangement trust for the purpose of
277 managing all health benefit plans established, maintained and offered
278 by such self-funded multiple employer welfare arrangement trust. Any
279 board of trustees shall have the authority to contract with any licensed
280 administrator or service company to administer the daily operations of

281 the health benefit plans;

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

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

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

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

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

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

309 (8) The self-funded multiple employer welfare arrangement trust
310 shall purchase and maintain commercially reasonable directors' and

311 officers' liability insurance from insurers licensed to transact the
312 business of insurance in this state;

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

316 (10) No self-funded multiple employer welfare arrangement trust
317 shall include in its name the words "insurance", "insurer", "underwriter",
318 "mutual" or any other word or term or combination of words or terms
319 that is descriptive of an insurance company or insurance business,
320 unless the context of such words or terms indicates that such self-funded
321 multiple employer welfare arrangement trust is not an insurance
322 company and is not transacting the business of insurance.

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

325 (1) Operate any health benefit plan in accordance with the fiduciary
326 standards set forth in the Consolidated Appropriations Act of 2021, P.L.
327 116-260, as amended from time to time, and all other generally accepted
328 fiduciary standards;

329 (2) Pay all costs assessed by the commissioner in accordance with title
330 38a of the general statutes. Such board of trustees shall have the
331 authority to collect fees on a pro rata basis from the participating
332 employers. No self-funded multiple employer welfare arrangement
333 trust shall be subject to (A) the health and welfare fee required under
334 section 19a-7j of the general statutes, (B) the public health fee required
335 under section 19a-7p of the general statutes, (C) any payment required
336 under section 38a-48 of the general statutes, or (D) the premium tax
337 required under section 12-202 of the general statutes.

338 (g) Each participating employer shall be (1) liable for such
339 participating employer's allocated share of the liabilities arising under a
340 health benefit plan provided by the self-funded multiple employer
341 welfare arrangement trust, as determined by the board of trustees, and

342 (2) jointly and severally liable for additional amounts if the annual
343 health benefit plan subscription amounts paid by all participating
344 employers of such plan result in a deficit of funds for the self-funded
345 multiple employer welfare arrangement trust. Each participating
346 employer's liability under this subsection shall not be assessed to
347 participating employees of such participating employer.

348 (h) Health benefit plan documents issued by any self-funded multiple
349 employer welfare arrangement trust to participating employers shall
350 have the following statement printed on the first page in fourteen-point
351 boldface type: "This health benefit plan is provided by a trust
352 established to provide health benefit plans to employees of employers
353 participating in a self-funded multiple employer welfare arrangement.
354 This health benefit plan is not insurance and is not offered through an
355 insurance company. This health benefit plan is not required to comply
356 with certain federal market requirements for health insurance, and is
357 not required to comply with certain state laws for health insurance. Each
358 participating employer shall be liable for such participating employer's
359 allocated share of the liabilities of the trust under all health benefit plans
360 offered by the trust, as determined by the board of trustees. Each
361 participating employer shall be jointly and severally liable for additional
362 amounts if the annual health benefit plan subscription amounts paid by
363 all participating employers and participating employees of such
364 participating employer result in a deficit of funds for the trust and for
365 any assessments by state regulators. The trust's financial statements
366 shall be made available upon request by any participating employer in
367 the self-funded multiple employer welfare arrangement."

368 (i) Health benefit plan documents issued by any self-funded multiple
369 employer welfare arrangement trust to participating employees shall
370 have the following statement printed on the first page in fourteen-point
371 boldface type: "This health benefit plan is provided by a trust
372 established to provide health benefit plans to employees of employers
373 participating in a self-funded multiple employer welfare arrangement,
374 including your employer. This health benefit plan is not insurance and

375 is not offered through an insurance company. This health benefit plan is
376 not required to comply with certain federal market requirements for
377 health insurance, and is not required to comply with certain state laws
378 for health insurance. Your employer shall be liable for such employer's
379 allocated share of the liabilities of the trust under all health benefit plans
380 offered by the trust, as determined by the board of trustees. Your
381 employer shall be jointly and severally liable for additional amounts if
382 the annual health benefit plan subscription amounts paid by all
383 participating employers and participating employees of such
384 participating employer result in a deficit of funds for the trust and for
385 any assessments by state regulators. The trust's financial statements
386 shall be made available to you upon request. The Consumer Affairs
387 Division within the Insurance Department is available to assist you with
388 questions that you may have concerning this health benefit plan." The
389 notice shall include the telephone number and electronic mail address
390 for the Consumer Affairs Division.

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

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

397 Sec. 504. Section 38a-567 of the general statutes is repealed and the
398 following is substituted in lieu thereof (*Effective April 1, 2026*):

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

403 (1) (A) Any such plan or arrangement shall be offered on a
404 guaranteed issue basis with respect to all eligible employees or
405 dependents of such employees, at the option of the small employer,

406 policyholder or contractholder, as the case may be.

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

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

435 (D) Any such plan or arrangement shall provide special enrollment
436 periods (i) to all eligible employees or dependents as set forth in 45 CFR
437 147.104, as amended from time to time, and (ii) for coverage under such
438 plan or arrangement ordered by a court for a spouse or minor child of

439 an eligible employee where request for enrollment is made not later than
440 thirty days after the issuance of such court order.

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

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

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

452 (ii) Gender;

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

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

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

464 (vi) Administrative cost savings resulting from the administration of
465 an association group plan or a plan written pursuant to section 5-259,
466 provided the savings reflect a reduction to the small employer carrier's
467 overall retention that is measurable and specifically realized on items

468 such as marketing, billing or claims paying functions taken on directly
469 by the plan administrator or association, except that such savings may
470 not reflect a reduction realized on commissions;

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

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

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

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

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

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

495 (iii) Premium rates for employees and dependents for
496 nongrandfathered plans shall be calculated for each covered individual
497 and premium rates for the small employer group shall be calculated by

498 totaling the premiums attributable to each covered individual.

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

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

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

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

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

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

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

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

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

547 (9) Any violation of subdivisions (3) to (7), inclusive, of this section
548 and of any regulations established under subdivision (8) of this section
549 shall be an unfair and prohibited practice under sections 38a-815 to 38a-
550 830, inclusive.

551 Sec. 505. Subsection (a) of section 38a-9 of the general statutes is
552 repealed and the following is substituted in lieu thereof (*Effective October*
553 *1, 2025*):

554 (a) Notwithstanding the provisions of section 4-8, there shall be a
555 Division of Consumer Affairs within the Insurance Department, which
556 division shall act on the Insurance Commissioner's behalf and at his
557 direction in order to carry out his responsibilities under this title with
558 respect to such matters. The division shall receive and review
559 complaints from residents of this state concerning their insurance

560 problems and problems arising out of multiple employer welfare
561 arrangement health benefit plans, as defined in section 502 of this act,
562 including claims disputes, and serve as a mediator in such disputes in
563 order to assist the commissioner in determining whether statutory
564 requirements and contractual obligations within the commissioner's
565 jurisdiction have been fulfilled. There shall be a director of said division,
566 who shall be provided with sufficient staff. The division shall serve to
567 coordinate all appropriate facilities in the department in addressing
568 such complaints, and conduct any outreach programs deemed
569 necessary to properly inform and educate the public on insurance
570 matters. The director shall submit quarterly reports to the
571 commissioner, which shall state the number of complaints received by
572 the division in such calendar quarter, the Connecticut premium or
573 premium equivalent volume of the appropriate line of each insurance
574 company or multiple employer welfare arrangement trust, as defined in
575 section 502 of this act, against which a complaint has been filed, the
576 types of complaints received, and the number of such complaints which
577 have been resolved. Such reports shall be published every six months
578 and copies shall be made available to any interested resident of this state
579 upon request. The commissioner shall report, in accordance with section
580 11-4a, to the joint standing committee of the General Assembly having
581 cognizance of matters relating to insurance on or before January
582 fifteenth annually, concerning the findings of such reports and
583 suggestions for legislative initiatives to address recurring problems.

584 Sec. 506. Section 38a-14 of the general statutes is repealed and the
585 following is substituted in lieu thereof (*Effective October 1, 2025*):

586 (a) For the purposes of this section, "company" means any insurance
587 company, multiple employer welfare arrangement trust, as defined in
588 section 502 of this act, or health care center doing business in this state,
589 any corporation or association collecting data utilized by any such
590 insurance company in the underwriting of insurance policies and any
591 corporation organized under any law of this state or having an office in
592 this state, which corporation is engaged in, or claiming or advertising

593 that it is engaged in, organizing or receiving subscriptions for or
594 disposing of stock of, or in any manner aiding or taking part in the
595 formation or business of, an insurance company or companies, or that is
596 holding the capital stock of one or more insurance corporations for the
597 purpose of controlling the management thereof, as voting trustees or
598 otherwise.

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

608 (c) (1) To carry out examinations under this section, the commissioner
609 may appoint one or more competent persons as examiners, who shall
610 not be officers of, connected with or interested in any company, other
611 than as policyholders. The commissioner may engage the services of
612 attorneys, appraisers, independent actuaries, independent certified
613 public accountants or other professionals and specialists as examiners
614 to assist the commissioner in conducting the examinations under this
615 section, the cost of which shall be borne by the company that is the
616 subject of the examination.

617 (2) In conducting the examination, the commissioner, the
618 commissioner's actuary or any examiner authorized by the
619 commissioner may examine, under oath, the officers and agents of such
620 a company, and all persons deemed to have material information
621 regarding the company's property or business. Each such company or
622 its officers and agents shall produce the books and papers in its or their
623 possession, relating to its business or affairs, and any other person may
624 be required to produce any book or paper in such person's custody that
625 is deemed to be relevant to such examination, for inspection by the

626 commissioner, the commissioner's actuary or examiners. The officers
627 and agents of the company shall facilitate the examination and aid the
628 examiners in making the same so far as it is in their power to do so. The
629 refusal of any company, by its officers, directors, employees or agents,
630 to submit to examination or to comply with any reasonable written
631 request of the examiners shall be grounds for suspension of, refusal of
632 or nonrenewal of any license or authority held by the company to
633 engage in an insurance or other business subject to the commissioner's
634 jurisdiction. Any such proceedings for suspension, revocation or refusal
635 of any license or authority shall be conducted pursuant to subsection (c)
636 of section 38a-41.

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

642 (d) In lieu of an examination under this section of any foreign or alien
643 insurer licensed in this state, the commissioner may accept an
644 examination report on such insurer prepared by the insurance
645 department for the insurer's state of domicile or port-of-entry state if (1)
646 such state's insurance department was, at the time of the examination,
647 accredited under the National Association of Insurance Commissioners'
648 financial regulation standards and accreditation program, or (2) the
649 examination is performed under the supervision of an accredited
650 insurance department or with the participation of one or more
651 examiners who are employed by such an accredited state insurance
652 department and who, after a review of the examination workpapers and
653 report, state under oath that the examination was performed in a
654 manner consistent with the standards and procedures required by their
655 insurance department.

656 (e) (1) Nothing contained in this section shall be construed to limit the
657 commissioner's authority to terminate or suspend any examination in
658 order to pursue legal or regulatory action pursuant to the insurance

659 laws of this state. Findings of fact and conclusions made pursuant to any
660 examination shall be prima facie evidence in any legal or regulatory
661 action.

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

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

691 (4) (A) The commissioner shall transmit the examination report

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

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

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

712 (2) Any investigatory hearing conducted under subparagraph (C) of
713 subdivision (3) of subsection (e) of this section by the commissioner or
714 the commissioner's authorized representative, shall be conducted as a
715 nonadversarial confidential investigatory proceeding as necessary for
716 the resolution of any inconsistencies, discrepancies or disputed issues
717 apparent (A) upon the filed examination report, (B) raised by or as a
718 result of the commissioner's review of relevant workpapers, or (C) by
719 the written submission or rebuttal of the company. Not later than
720 twenty days after the conclusion of any such hearing, the commissioner
721 shall enter an order pursuant to subparagraph (A) of subdivision (3) of
722 subsection (e) of this section. The commissioner shall not appoint an
723 examiner as an authorized representative to conduct the hearing. The
724 hearing shall proceed expeditiously with discovery by the company

725 limited to the examiner's workpapers that tend to substantiate any
726 assertions set forth in any written submission or rebuttal. The
727 commissioner or the commissioner's authorized representative may
728 issue subpoenas for the attendance of any witnesses or the production
729 of any documents deemed relevant to the investigation, whether under
730 the control of the department, the company or other persons. The
731 documents produced shall be included in the record and testimony
732 taken by the commissioner or the commissioner's authorized
733 representative shall be under oath and preserved for the record.
734 Nothing contained in this section shall require the department to
735 disclose any information or records that would indicate or show the
736 existence or content of any investigation or activity of a criminal justice
737 agency. The hearing shall proceed with the commissioner or the
738 commissioner's authorized representative posing questions to the
739 persons subpoenaed. Thereafter, the company and the Insurance
740 Department may present testimony relevant to the investigation. Cross-
741 examination shall be conducted only by the commissioner or the
742 commissioner's authorized representative. The company and the
743 Insurance Department shall be permitted to make closing statements
744 and may be represented by counsel of their choice.

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

748 (h) The commissioner shall, at least once in every five years, visit and
749 examine the affairs of each domestic insurer, domestic health care
750 center, domestic fraternal benefit society, multiple employer welfare
751 arrangement trust, as defined in section 502 of this act and foreign and
752 alien insurer doing business in this state. Notwithstanding subdivision
753 (1) of subsection (c) of this section, no domestic insurer or such other
754 domestic entity subject to examination under this section shall pay as
755 costs associated with the examination the salaries, fringe benefits or
756 travel and maintenance expenses of examining personnel of the
757 Insurance Department engaged in such examination if such domestic

758 insurer or domestic entity is otherwise liable to assessment levied under
759 section 38a-47, except that a domestic insurer or such other domestic
760 entity shall pay the travel and maintenance expenses of examining
761 personnel of the Insurance Department when such insurer or entity is
762 examined outside the state.

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

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

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

788 (2) No cause of action shall arise nor shall any liability be imposed
789 against the commissioner, the commissioner's authorized

790 representatives or any examiner appointed by the commissioner for any
791 statements made or conduct performed in good faith while carrying out
792 the provisions of this section.

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

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

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

810 Sec. 507. Section 38a-15 of the general statutes is repealed and the
811 following is substituted in lieu thereof (*Effective October 1, 2025*):

812 (a) The commissioner shall, as often as the commissioner deems it
813 expedient, undertake a market conduct examination of the affairs of any
814 insurance company, health care center, multiple employer welfare
815 arrangement trust, as defined in section 502 of this act, third-party
816 administrator, as defined in section 38a-720, or fraternal benefit society
817 doing business in this state. Any such examination may be conducted in
818 accordance with the procedures and definitions set forth in the National
819 Association of Insurance Commissioners' Market Regulation
820 Handbook.

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

844 (c) Each market conduct examiner shall make a full and true report
845 of each market conduct examination made by such examiner, which
846 shall comprise only facts appearing upon the books, papers, records or
847 documents of the examined company, center, multiple employer
848 welfare arrangement trust, administrator or society or ascertained from
849 the sworn testimony of its officers or agents or of other persons
850 examined under oath concerning its affairs. The examiner's report shall
851 be presumptive evidence of the facts therein stated in any action or
852 proceeding in the name of the state against the company, center,
853 multiple employer welfare arrangement trust, administrator or society,
854 its officers or agents. The commissioner shall grant a hearing to the

855 company, center, multiple employer welfare arrangement trust,
856 administrator or society examined before filing any such report and may
857 withhold any such report from public inspection for such time as the
858 commissioner deems proper. The commissioner may, if the
859 commissioner deems it in the public interest, publish any such report,
860 or the result of any such examination contained therein, in one or more
861 newspapers of the state.

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

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

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

882 (2) No cause of action shall arise nor shall any liability be imposed
883 against any person for the act of communicating or delivering
884 information or data pursuant to an examination made under the
885 authority of this section to the commissioner, the commissioner's
886 authorized representative or an examiner if such communication or

887 delivery was performed in good faith and without fraudulent intent or
888 the intent to deceive.

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

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

901 (g) All workpapers, recorded information, documents and copies
902 thereof produced by, obtained by or disclosed to the commissioner or
903 any other person in the course of an examination made under the
904 authority of this section shall be confidential, shall not be subject to
905 subpoena and shall not be made public by the commissioner or any
906 other person, except to the extent provided in subsection (f) of this
907 section. The commissioner may grant access to such workpapers,
908 recorded information, documents and copies to the National
909 Association of Insurance Commissioners, provided said association
910 agrees, in writing, to hold such workpapers, recorded information,
911 documents and copies thereof confidential.

912 Sec. 508. Subsection (a) of section 19a-755a of the general statutes is
913 repealed and the following is substituted in lieu thereof (*Effective October*
914 *1, 2025*):

915 (a) As used in this section:

916 (1) "All-payer claims database" means a database that receives and
917 stores data from a reporting entity relating to medical insurance claims,

918 dental insurance claims, pharmacy claims and other insurance claims
919 information from enrollment and eligibility files.

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

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

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

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

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

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

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

930 (vii) A nonprofit medical service corporation, as defined in section
931 38a-214;

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

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

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

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

940 (xii) A multiple employer welfare arrangement trust, as defined in
941 section 502 of this act.

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

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	<i>October 1, 2025</i>	38a-1
Sec. 502	<i>October 1, 2025</i>	New section
Sec. 503	<i>October 1, 2025</i>	New section
Sec. 504	<i>April 1, 2026</i>	38a-567
Sec. 505	<i>October 1, 2025</i>	38a-9(a)
Sec. 506	<i>October 1, 2025</i>	38a-14
Sec. 507	<i>October 1, 2025</i>	38a-15
Sec. 508	<i>October 1, 2025</i>	19a-755a(a)