



General Assembly

**Amendment**

January Session, 2025

LCO No. 7599



Offered by:

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

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

SEN. PERILLO J., 21<sup>st</sup> Dist.

To: Subst. Senate Bill No. **1469**

File No. 382

Cal. No. 233

**"AN ACT CONCERNING MEDICAL DEBT."**

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 Section 38a-1 of the general statutes is repealed and the  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- 477ll 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 refiling 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)