General Assembly

Amendment

January Session, 2025

LCO No. **8927**

Offered by:
SEN. HARDING, 30th Dist.
SEN. HWANG, 28th Dist.

To: Subst. Senate Bill No. **10** File No. 419 Cal. No. 241

(As Amended)

"AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION."

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

"Section 1. (NEW) (*Effective October 1, 2025*) For the purposes of this section and sections 2, 3 and 5 of this act:

(1) "Commissioner" means the Insurance Commissioner;

(2) "Employer member" means an entity in this state that is part of a sponsoring association, conducts business in this state and employs individuals in this state;

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

(4) "Fully insured multiple employer welfare arrangement" means any health benefit plan offered by a sponsoring association for the purpose of providing insurance to participating employees of a sponsoring association that is funded through a policy of insurance issued by a licensed insurance company in this state;

(5) "Health enhancement program" means any health benefit program that ensures access and removes barriers to essential, high-value clinical services;

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

(7) "Self-funded multiple employer welfare arrangement" means any health benefit plan offered by a sponsoring association, that is not fully insured by a licensed insurance company in this state, for the purpose of providing insurance to participating employer members of a sponsoring association;

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

(9) "Value-based insurance design" means any material term in a health insurance policy that is designed to increase the quality of covered benefits or health care services while reducing the cost of such policy, benefits or health care services.

Sec. 2. (NEW) (*Effective October 1, 2025*) (a) No self-funded multiple employer welfare arrangement shall issue any health benefit plan in this state unless such self-funded multiple employer welfare arrangement first obtains a license from the commissioner.

(b) Any health benefit plan issued by a self-funded multiple employer welfare arrangement that covers one or more employees of one or more participating employer members of a sponsoring association shall:

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

(2) Offer a minimum level of coverage designed to provide health benefits that are actuarially equivalent to not less than sixty per cent of the full actuarial value of the benefits provided under the health benefit plan and include coverage for inpatient hospital services and physician services;

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

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

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

(6) Utilize each employer member's risk profile to determine premiums by actuarially adjusting above or below established base rates, and utilize pooling or reinsurance of individual large claimants to reduce the adverse impact on any specific employer member's premiums;

(7) Make any health benefit plan available to all employer members of a sponsoring association regardless of any factor relating to the health status of such employer members or individuals eligible for coverage

through any employer member;

(8) Implement value-based insurance design and value-based contracting by administering programs, which may include, but are not limited to, centers of excellence, wellness programs, health enhancement programs, alternative payment models, chronic disease navigation, patient-centered medical homes and advanced primary care; and

(9) Comply with the notification requirements to covered persons set forth in sections 38a-591d, 38a-591e and 38a-591f of the general statutes with respect to utilization review and benefit determinations of a benefit request or claim.

(c) Any sponsoring association shall form a trust that shall establish and maintain any health benefit plans for such sponsoring association. Such trust shall be authorized to sell health benefit plans to employer members of the sponsoring association by meeting the following conditions:

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

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

(3) Any organizational documents for a trust shall:

(A) State that such trust is sponsored by the sponsoring association;

(B) State that the purpose of such trust is to provide health care benefits, including, but not limited to, medical, prescription drug, dental and vision benefits, to participating employees of the sponsoring association or its members, and the dependents of such participating employees or members, through health benefit plans;

(C) Provide that trust funds shall be used for the benefit of participating employees of the sponsoring association and the dependents of such participating employees, through (i) self-funding of claims or the purchase of reinsurance, or any combination thereof, and (ii) defraying the costs and expenses of administering and operating such trust and any health benefit plan;

(D) Limit participation in any health benefit plan to participating employees of the sponsoring association and such sponsoring association's employer members;

(E) Establish and maintain a board of trustees, composed of not less than five trustees, that shall have fiscal control over such self-funded multiple employer welfare arrangement. Any board of trustees shall have the authority to (i) approve applications of association employer members for participation in the self-funded multiple employer welfare arrangement, and (ii) contract with any licensed administrator or service company to administer the daily operations of the self-funded multiple employer welfare arrangement;

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

(G) Require each trustee to discharge such trustee's duties in accordance with generally accepted fiduciary standards, as determined by the commissioner, in accordance with the provisions of chapter 54 of the general statutes;

(4) The trust shall establish and maintain reserves calculated in accordance with the accounting requirements of the National Association of Insurance Commissioners Accounting Practices and

Procedures Manual, version effective January 1, 2001, and subsequent revisions, and in accordance with any financial and solvency regulations adopted by the commissioner, in accordance with the provisions of chapter 54 of the general statutes;

(5) The trust shall purchase and maintain an insurance policy providing coverage for stop-loss insurance with retention levels determined in accordance with actuarial principles from insurers licensed to transact the business of insurance in this state;

(6) The trust shall purchase and maintain commercially reasonable fiduciary liability insurance from insurers licensed to transact the business of insurance in this state;

(7) The trust shall purchase and maintain a bond in an amount and form approved by the commissioner; and

(8) No trust shall include in its name, the words "insurance", "insurer", "underwriter", "mutual" or any other word or term or combination of words or terms that is descriptive of an insurance company or insurance business, unless the context of such words or terms indicate that such trust is not an insurance company and is not transacting the business of insurance.

(d) Any board of trustees established pursuant to subsection (c) of this section shall:

(1) Operate any health benefit plans in accordance with generally accepted fiduciary standards, as established in regulations adopted by the commissioner, in accordance with the provisions of chapter 54 of the general statutes; and

(2) Have the authority to collect special assessments against employer members and enforce the collection of such special assessments.

(e) Each employer member shall be liable for such employer member's allocated share of the liabilities of the sponsoring association

under any health benefit plan, as determined by the board of trustees.

(f) Health benefit plan documents issued by any such self-funded multiple employer welfare arrangement shall have the following statement printed on the first page in fourteen-point boldface type: "This coverage is not insurance and is not offered through an insurance company. This coverage is not required to comply with certain federal market requirements for health insurance, and is not required to comply with certain state laws for health insurance. Each employer member shall be liable for such employer member's allocated share of the liabilities of the sponsoring association under the health benefit plans as determined by the board of trustees. Each employer member may be responsible for paying an additional sum if the annual premiums present a deficit of funds for the trust. The trust's financial documents shall be made available upon request by a participant in the health benefit plan."

(g) This section shall not apply to any fully insured multiple employer welfare arrangement that offers or provides any health benefit plan that is fully insured by any insurer authorized to transact the business of insurance in this state.

(h) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section, including, but not limited to, the requirements of self-funded multiple employer welfare arrangements for: (1) Licensing; (2) financial condition and actuarial standards; (3) solvency and insolvency, including, but not limited to, the use of trust deposits and security bonds; (4) transparency and reporting; and (5) filings.

Sec. 3. (NEW) (*Effective October 1, 2025*) (a) Any sponsoring association that sponsors any fully insured multiple employer welfare arrangement shall have a written constitution and bylaws that require:

(1) The sponsoring association to hold regular meetings not less than once annually to further the purposes of such sponsoring association's

participating employers; and

(2) The sponsoring association to collect dues or solicit contributions from such sponsoring association's participating employers.

(b) Any health benefit plan issued by any fully insured multiple employer welfare arrangement shall:

(1) Comply with regulations or standards prescribed by the United States Department of Labor pertaining to multiple employer welfare arrangements;

(2) Qualify as a large group market plan subject to (A) all coverage mandates under chapter 700c of the general statutes applicable to a large group market plan offered in this state, and (B) the large group market insurance regulations pursuant to the Public Health Service Act, 42 USC 2791, as amended from time to time;

(3) Adhere to the group health plan coverage requirements under the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time;

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

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

(6) Offer a minimum level of coverage designed to provide benefits that are actuarially equivalent to not less than sixty per cent of the full actuarial value of the benefits provided under the health benefit plan; and

(7) Be available only to participating employers of the fully insured multiple employer welfare arrangement.

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

Health insurance plans **[**, associations of small employers**]** and other insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

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

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

(C) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as set forth in this subparagraph only if the carrier effects

the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

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

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

(B) With respect to grandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all grandfathered plans, adjusted to reflect one or more of the following classifications:

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

(ii) Gender;

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

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

than five per cent per year;

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

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

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

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

(C) (i) With respect to nongrandfathered plans issued to small employers, the premium rates charged or offered shall be established on the basis of a single pool of all nongrandfathered plans, adjusted to reflect one or more of the following classifications:

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

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

(ii) Total premium rates for family coverage for nongrandfathered

plans shall be determined by adding the premiums for each individual family member, except that with respect to family members under twenty-one years of age, the premiums for only the three oldest covered children shall be taken into account in determining the total premium rate for such family.

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

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

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

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

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

(4) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small

employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

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

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

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

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

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

Sec. 5. (*Effective from passage*) (a) For the purposes of this section:

(1) "Stop-loss insurance plan" means any insurance policy purchased by any employer, insurer, multiple employer welfare arrangement or other provider of fully insured or self-funded small group health coverage in this state that limits the financial risk of medical costs for such employer, insurer, multiple employer welfare arrangement or other provider of fully insured or self-funded small group health coverage; and

(2) "Small group" means any employer or other purchaser of a stop-loss insurance plan with not more than one hundred employees or members.

(b) There is established a task force to study the structure of stop-loss insurance plans and any impact that such plans may have on (1) small groups and such groups' enrollees, and (2) medical spending in this state.

(c) The task force shall make recommendations concerning: (1) Measures to ensure access to affordable health care services to purchasers of stop-loss insurance plans and such purchasers' enrollees in health coverage utilizing stop-loss insurance plans; (2) any financial impact that stop-loss insurance plans may have on (A) small groups in this state, (B) enrollees and such enrollees' family members, and (C) the fully insured health insurance market in this state; (3) the appropriate role of stop-loss insurance plans in this state; and (4) consumer protections for small groups, such small groups' enrollees and such enrollees' family members covered by stop-loss insurance plans in this state.

(d) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of a small group in this state utilizing a stop-loss insurance plan, and one of whom shall be a representative of a small group in this state offering health coverage that does not utilize a stop-loss insurance plan;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall have experience in managing employee benefits and be knowledgeable with respect to stop-loss insurance in this state, and one of whom shall be an insurance producer licensed in this state and be knowledgeable with respect to stop-loss insurance in this state;

(3) One appointed by the majority leader of the House of Representatives, who shall be a physician licensed pursuant to chapter 370 of the general statutes;

(4) One appointed by the majority leader of the Senate, who shall be a representative of an advocacy organization focused on health equity;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of the Connecticut Association of Health Plans;

(6) One appointed by the minority leader of the Senate, who shall be a representative of the Connecticut Business and Industry Association;

(7) The Healthcare Advocate, or the Healthcare Advocate's designee; and

(8) Three persons appointed by the Governor, one of whom shall be a representative of a labor organization, one of whom shall be a representative of an insurance carrier licensed to issue stop-loss insurance plans in this state and one of whom shall be a representative of a consumer advocacy organization.

(e) All initial appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(f) The members of the task force shall select one or two chairpersons of the task force from among the members of the task force. Such chairperson or chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date

of this section.

(g) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the task force.

(h) Not later than February 1, 2026, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or February 1, 2026, whichever is later."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2025*	New section
Sec. 2	*October 1, 2025*	New section
Sec. 3	*October 1, 2025*	New section
Sec. 4	*October 1, 2025*	38a-567
Sec. 5	*from passage*	New section