House of Representatives

General Assembly

File No. 246

February Session, 2026

Substitute House Bill No. 5378

House of Representatives, March 30, 2026

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND REQUIRING A STUDY OF THE FEASIBILITY OF ESTABLISHING THE CONNECTICUT OPTION PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-1 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

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

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

(2) "Alien insurer" means any insurer that has been chartered by or organized or constituted within or under the laws of any jurisdiction or country without the United States.

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

(4) "Commissioner" means the Insurance Commissioner.

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

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

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

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

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

(10) "Insolvency" or "insolvent" means, for any insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (A) Capital and surplus required by law for its organization and continued operation; or (B) the total par or stated value of its authorized and issued capital stock. For purposes of this subdivision "liabilities" shall include but not be limited to reserves required by statute or by regulations adopted by

the commissioner in accordance with the provisions of chapter 54 or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. (NEW) (*Effective January 1, 2027*) For the purposes of this section and section 3 of this act:

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

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

(3) "Employer member" means an entity domiciled in this state or that maintains such entity's commercial domicile in this state, is a member of a sponsoring association and employs more than one individual in this state. "Employer member" may include such employer member's

sponsoring association that is domiciled in this state and employs more than one individual in this state;

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

(5) "Health benefit plan" means a contract, certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state by a self-funded multiple employer welfare arrangement trust to provide, deliver, arrange for, pay for or reimburse any of the costs of the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. "Health benefit plan" does not include insurance products;

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

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

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

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

(10) "Self-funded multiple employer welfare arrangement" means a program established or maintained on behalf of employer members and offered by a self-funded multiple employer welfare arrangement trust for the purpose of providing one or more health benefit plans for such employer member's employees and such employees' dependents;

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

(12) "Sponsoring association" means any industry trade group or any

other trade group with employer members representing multiple trades domiciled in this state that (A) is organized and has a written constitution or bylaws, (B) has not less than five hundred employees of not less than twenty-five 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

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

Sec. 3. (NEW) (*Effective January 1, 2027*) (a) No person, other than a self-funded multiple employer welfare arrangement trust, shall establish or operate a self-funded multiple employer welfare arrangement in this state.

(b) Any self-funded multiple employer welfare arrangement trust, prior to establishing a self-funded multiple employer welfare arrangement in this state, shall apply for and obtain a license from the commissioner. The commissioner shall issue a license to such self-funded multiple employer welfare arrangement trust, provided such trust satisfies all licensing requirements applicable to a health insurance company pursuant to chapter 698 of the general statutes. Upon the issuance of a license by the commissioner to a self-funded multiple employer welfare arrangement trust, in accordance with the provisions of this subsection, such trust shall comply with all requirements applicable to health insurance companies set forth in title 38a of the general statutes and any regulations adopted by the commissioner in accordance with the provisions of chapter 54 of the general statutes.

(c) (1) The commissioner shall not issue a license to a self-funded multiple employer welfare arrangement trust pursuant to subsection (b) of this section, unless such trust has an initial combined capital and surplus of (A) not less than four million dollars, or (B) an amount determined by the commissioner under the provisions of regulations adopted pursuant to subsection (k) of this section.

(2) Beginning on April 1, 2027, any self-funded multiple employer welfare arrangement trust that meets the licensing requirements pursuant to subsection (b) of this section may offer a health benefit plan to participating employees of one or more participating employers.

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

(1) Provide coverage for 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;

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

(3) Not limit or exclude coverage for any individual by imposing a 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 rate or contribution requirements;

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

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

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

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

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

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

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

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

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

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

(2) A Form M-1 shall be filed each year by such trust 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 the self-funded multiple employer welfare arrangement trust; and (B) a description of the health benefit plans offered through such self-funded multiple employer welfare arrangement trust;

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

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

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

(C) Provide that self-funded multiple employer welfare arrangement trust funds shall be used for the benefit of eligible employers 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 self-funded multiple employer welfare arrangement trust and any health benefit plan issued by such trust;

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

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

the health benefit plans;

(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;

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

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

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

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

(8) The self-funded multiple employer welfare arrangement trust shall purchase and maintain commercially reasonable directors' and officers' liability insurance from insurers licensed to transact the

business of insurance in this state;

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

(10) No self-funded multiple employer welfare arrangement 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 are descriptive of an insurance company or insurance business, unless the context of such words or terms indicates that such self-funded multiple employer welfare arrangement trust is not an insurance company and is not transacting the business of insurance.

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

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

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

(g) Each participating employer shall be (1) liable for such participating employer's allocated share of the liabilities arising under a health benefit plan provided by the self-funded multiple employer welfare arrangement trust, as determined by the board of trustees, and (2) jointly and severally liable for additional amounts if the annual

health benefit plan subscription amounts paid by all participating employers of such plan result in a deficit of funds for the self-funded multiple employer welfare arrangement trust. Each participating employer's liability under this subsection shall not be assessed to participating employees of such participating employer.

(h) Health benefit plan documents issued by any self-funded multiple employer welfare arrangement trust to participating employers shall have the following statement printed on the first page in fourteen-point boldface type: "This health benefit plan is provided by a trust established to provide health benefit plans to employees of employers participating in a self-funded multiple employer welfare arrangement. This health benefit plan is not insurance and is not offered through an insurance company. This health benefit plan 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 participating employer shall be liable for such participating employer's allocated share of the liabilities of the trust under all health benefit plans offered by the trust, as determined by the board of trustees. Each participating employer shall be jointly and severally liable for additional amounts if the annual health benefit plan subscription amounts paid by all participating employers and participating employees of such participating employer result in a deficit of funds for the trust and for any assessments by state regulators. The trust's financial statements shall be made available upon request by any participating employer in the self-funded multiple employer welfare arrangement.".

(i) Health benefit plan documents issued by any self-funded multiple employer welfare arrangement trust to participating employees shall have the following statement printed on the first page in fourteen-point boldface type: "This health benefit plan is provided by a trust established to provide health benefit plans to employees of employers participating in a self-funded multiple employer welfare arrangement, including your employer. This health benefit plan is not insurance and is not offered through an insurance company. This health benefit plan 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. Your employer shall be liable for such employer's allocated share of the liabilities of the trust under all health benefit plans offered by the trust, as determined by the board of trustees. Your employer shall be jointly and severally liable for additional amounts if the annual health benefit plan subscription amounts paid by all participating employers and participating employees of such participating employer result in a deficit of funds for the trust and for any assessments by state regulators. The trust's financial statements shall be made available to you upon request. The Consumer Affairs Division within the Insurance Department is available to assist you with questions that you may have concerning this health benefit plan.". The notice shall include the telephone number and electronic mail address for the Consumer Affairs Division.

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

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

Sec. 4. Section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

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, except as a member of an association of 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, except as a member of an association of 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. Subsection (a) of section 38a-9 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

(a) Notwithstanding the provisions of section 4-8, there shall be a Division of Consumer Affairs within the Insurance Department, which division shall act on the Insurance Commissioner's behalf and at his direction in order to carry out his responsibilities under this title with respect to such matters. The division shall receive and review complaints from residents of this state concerning their insurance problems and problems arising out of health benefit plans, as defined in section 2 of this act, including claims disputes, and serve as a mediator in such disputes in order to assist the commissioner in determining whether statutory requirements and contractual obligations within the commissioner's jurisdiction have been fulfilled. There shall be a director

of said division, who shall be provided with sufficient staff. The division shall serve to coordinate all appropriate facilities in the department in addressing such complaints, and conduct any outreach programs deemed necessary to properly inform and educate the public on insurance matters. The director shall submit quarterly reports to the commissioner, which shall state the number of complaints received by the division in such calendar quarter, the Connecticut premium or premium equivalent volume of the appropriate line of each insurance company or self-funded multiple employer welfare arrangement trust, as defined in section 2 of this act, against which a complaint has been filed, the types of complaints received, and the number of such complaints which have been resolved. Such reports shall be published every six months and copies shall be made available to any interested resident of this state upon request. The commissioner shall report, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance on or before January fifteenth annually, concerning the findings of such reports and suggestions for legislative initiatives to address recurring problems.

Sec. 6. Section 38a-14 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

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

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

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

(2) In conducting the examination, the commissioner, the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such a company, and all persons deemed to have material information regarding the company's property or business. Each such company or its officers and agents shall produce the books and papers in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper in such person's custody that is deemed to be relevant to such examination, for inspection by the commissioner, the commissioner's actuary or examiners. The officers and agents of the company shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension of, refusal of or nonrenewal of any license or authority held by the company to

engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to subsection (c) of section 38a-41.

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

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

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

(2) Nothing contained in this section shall be construed to limit the commissioner's authority in such legal or regulatory action to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or

any other information discovered or developed during the course of any examination.

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

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

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

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

(2) Any investigatory hearing conducted under subparagraph (C) of subdivision (3) of subsection (e) of this section by the commissioner or the commissioner's authorized representative, shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent (A) upon the filed examination report, (B) raised by or as a result of the commissioner's review of relevant workpapers, or (C) by the written submission or rebuttal of the company. Not later than twenty days after the conclusion of any such hearing, the commissioner shall enter an order pursuant to subparagraph (A) of subdivision (3) of subsection (e) of this section. The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's authorized representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation, whether under the control of the department, the company or other persons. The documents produced shall be included in the record and testimony taken by the commissioner or the commissioner's authorized representative shall be under oath and preserved for the record.

Nothing contained in this section shall require the department to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency. The hearing shall proceed with the commissioner or the commissioner's authorized representative posing questions to the persons subpoenaed. Thereafter, the company and the Insurance Department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the commissioner or the commissioner's authorized representative. The company and the Insurance Department shall be permitted to make closing statements and may be represented by counsel of their choice.

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

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

(i) Nothing contained in this section shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Insurance Department of this or any other

state or country, or to law enforcement officials of this or any other state or to any agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees, in writing, to hold such report and matters relating thereto confidential.

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

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

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

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

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

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

Sec. 7. Section 38a-15 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

(a) The commissioner shall, as often as the commissioner deems it expedient, undertake a market conduct examination of the affairs of any insurance company, health care center, self-funded multiple employer welfare arrangement trust, as defined in section 2 of this act, third-party administrator, as defined in section 38a-720, or fraternal benefit society doing business in this state. Any such examination may be conducted in accordance with the procedures and definitions set forth in the National Association of Insurance Commissioners' Market Regulation Handbook.

(b) To carry out the examinations under this section, the commissioner may appoint, as market conduct examiners, one or more competent persons, who shall not be officers of, or connected with or interested in, any insurance company, health care center, self-funded multiple employer welfare arrangement trust, third-party administrator or fraternal benefit society, other than as a policyholder. In conducting the examination, the commissioner, the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such insurance company, health care center, self-funded multiple employer welfare arrangement trust, third-party administrator or fraternal benefit society and all persons deemed to have material information regarding the company's, center's, self-

funded multiple employer welfare arrangement trust's, administrator's or society's property or business. Each such company, center, self-funded multiple employer welfare arrangement trust, administrator or society, its officers and agents, shall produce the books and papers, in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper in such person's custody, deemed to be relevant to the examination, for the inspection of the commissioner, the commissioner's actuary or examiners, when required. The officers and agents of the company, center, self-funded multiple employer welfare arrangement trust, administrator or society shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so.

(c) Each market conduct examiner shall make a full and true report of each market conduct examination made by such examiner, which shall comprise only facts appearing upon the books, papers, records or documents of the examined company, center, self-funded multiple employer welfare arrangement trust, administrator or society or ascertained from the sworn testimony of its officers or agents or of other persons examined under oath concerning its affairs. The examiner's report shall be presumptive evidence of the facts therein stated in any action or proceeding in the name of the state against the company, center, self-funded multiple employer welfare arrangement trust, administrator or society, its officers or agents. The commissioner shall grant a hearing to the company, center, self-funded multiple employer welfare arrangement trust, administrator or society examined before filing any such report and may withhold any such report from public inspection for such time as the commissioner deems proper. The commissioner may, if the commissioner deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

(d) (1) All the expense of any examination made under the authority of this section, other than examinations of domestic insurance companies and domestic health care centers, shall be paid by the company, center, self-funded multiple employer welfare arrangement

trust, administrator or society examined.

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

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

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

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

(f) Nothing in this section shall be construed to prevent or prohibit the commissioner from disclosing at any time the content or results of an examination report or a preliminary examination report or any matter relating to such report, to (1) the insurance regulatory officials of this state or any other state or country, (2) law enforcement officials of this or any other state, or (3) any agency of this or any other state or of

the federal government, provided such officials or agency receiving the report or matters relating to the report agrees, in writing, to hold such report or matters confidential.

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

Sec. 8. (*Effective from passage*) (a) As used in this section:

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted pursuant to said acts;

(2) "Connecticut Option program" means a standardized health benefit plan designed by the state to reduce health care coverage costs and made available through private or commercial insurance carriers to individuals in the state;

(3) "Exchange" means the Connecticut Health Insurance Exchange established under section 38a-1081 of the general statutes;

(4) "Health benefit plan" has the same meaning as provided in section 38a-1080 of the general statutes;

(5) "State innovation waiver" means a waiver of one or more requirements of the Affordable Care Act authorized under Section 1332 of said act; and

(6) "Secretary" means the Secretary of the Office of Policy and Management.

(b) The Office of Policy and Management shall, within available resources, study the feasibility of establishing the Connecticut Option program with the goal of reducing health insurance premiums. The study shall include analyses, conclusions and recommendations sufficient for the secretary, in consultation with the Insurance Commissioner, to evaluate and compare design models. The study shall include, but need not be limited to:

(1) A review of the efficacy, impact and reasonableness of proposed program design elements, including, but not limited to: (A) Provider reimbursement methodologies; (B) value-based or performance-based contracting arrangements; (C) enrollee cost-sharing and premium affordability targets; (D) incentives or rewards for the delivery of high-quality, cost-effective health care; and (E) any state-specific premium assistance programs or risk stabilization programs, including, but not limited to, a state-operated reinsurance program that may maximize available federal funding pursuant to a state innovation waiver under Section 1332 of the Affordable Care Act;

(2) Identification of any necessary statutory or regulatory changes required for implementation;

(3) Determination of staffing needs across state agencies to effectively implement the Connecticut Option program;

(4) Analysis of the state insurance market and projected impacts of the Connecticut Option program on persons who receive health care coverage through the exchange; and

(5) Required state action or design elements needed to achieve multiple premium savings targets.

(c) Not later than January 15, 2027, the secretary shall file an interim report, in accordance with the provisions of section 11-4a of the general statutes, on the study conducted pursuant to subsection (b) of this

section with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services and insurance and real estate. Not later than January 31, 2028, the secretary shall file a final report, in accordance with the provisions of section 11-4a of the general statutes, on the feasibility of the Connecticut Option program and any recommendations on implementing the program with the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, human services and insurance and real estate.

(d) If the secretary, in consultation with the Insurance Commissioner, determines a Connecticut Option program is feasible after completion of the study or related reports pursuant to subsections (b) and (c) of this section, the secretary may direct the relevant state agency to develop and implement a waiver under Section 1332 of the Affordable Care Act or any applicable waiver from federal law that may be required to maximize federal funding for the program or any component part of a program design to help achieve health care savings.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2027*	38a-1
Sec. 2	*January 1, 2027*	New section
Sec. 3	*January 1, 2027*	New section
Sec. 4	*January 1, 2027*	38a-567
Sec. 5	*January 1, 2027*	38a-9(a)
Sec. 6	*January 1, 2027*	38a-14
Sec. 7	*January 1, 2027*	38a-15
Sec. 8	*from passage*	New section

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 27 $	FY 28 $	FY 29 $
Policy & Mgmt., Off.	GF - Cost	1 million	None	None
Connecticut Health Insurance Exchange	EF - Revenue Impact	None	None	Potential
Insurance Dept.	IF - Cost	See Below	See Below	See Below
Insurance Dept.	IF - Revenue Gain	See Below	See Below	See Below
Insurance Dept.	GF - Potential Revenue Gain	Minimal	Minimal	Minimal
Department of Revenue Services	GF - Revenue Impact	None	Potential	Potential

Note: EF=Enterprise Fund; IF=Insurance Fund; GF=General Fund

Municipal Impact: None

Explanation

The bill authorizes a self-funded multiple employer welfare arrangement (MEWA) trust, once licensed by the Insurance Department (DOI), to administer a health benefit plan that is not insurance but must follow most of the rules for health insurance companies in the state. It also permits associations of small employers purchasing health insurance in the fully insured market to be subject to large group rating rules in certain circumstances.

The bill results in: (1) costs and offsetting revenue to DOI associated with regulating the self-funded MEWA trusts beginning as early as FY 27, (2) a potential minimal revenue gain to the General Fund from license and filing fees of any new entities formed, (3) a potential revenue impact to the General Fund associated with insurance premiums tax beginning in FY 28, and (4) a potential revenue impact to the

Connecticut Health Insurance Exchange ("exchange") beginning in FY 29.

The bill also requires the Office of Policy Management (OPM) to study the feasibility of establishing the Connecticut Option program and provide a report by January 15, 2027. This results in a one-time cost of $1 million to OPM in FY 27 for a consultant to conduct the study and provide the report.

State Regulation Fiscal Impacts

The total annual costs for state regulation of self-funded MEWAs will depend on the number of such entities that are established; however, the cost per year to DOI is anticipated to exceed $18,000 each.[1] The bill requires that self-funded MEWAs reimburse DOI for costs associated with their financial and market conduct examinations, so costs to DOI under the bill will be mostly offset by Insurance Fund revenue gains to the agency.

Costs related to regulating self-funded MEWA trusts could be incurred beginning in FY 27, as the bill allows them to apply for a license beginning as early as January 1, 2027, and to start offering health benefit plans, once licensed, beginning April 1, 2027. The entities will bear the cost of the contracted services of attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals required to supplement agency staffing in order to complete their financial examinations and market conduct reviews. They will also be billed for Insurance Department staff time in connection with those examinations and reviews.

The bill gives employees covered by self-funded MEWA trusts' health benefit plans access to the Division of Consumer Affairs at DOI,

[1]This figure ($18,000 per trust) reflects the staff time, at both analyst and supervisor hourly rates, anticipated to be required to handle the new volume of work associated with quarterly financial analysis of one such entity. A typical market conduct examination is approximately $100,000, which would typically be done once every three to five years.

which could result in staff costs to the Insurance Fund, to the extent additional staff are needed to handle the volume of complaints and questions received. One additional Health Unit insurance examiner at a cost of $147,000 annually ($79,000 for salary and $68,000 for fringe benefits) is anticipated to be required if approximately 100,000 people become covered by the trusts.

The bill requires the trusts to pay the same license and filing fees applicable to health insurance companies, which include: (1) the pre-license document filing fee of $220, (2) the annual license fee of $200, and (3) the annual report fee of $50. To the extent self-funded MEWA trusts are formed and apply for licensure, the bill results in a minimal annual revenue gain to the General Fund associated with these fees beginning as early as FY 27. The bill allows DOI to adopt implementing regulations, which has no fiscal impact because the agency has the necessary expertise.

State Tax and Exchange Revenue Impacts

The bill may result in a change to the amount of net direct written premiums in the fully insured market beginning in FY 27, with a potential revenue impact beginning in FY 28, to the extent small employers currently purchasing health insurance instead participate in the new health plans permitted under the bill.[2]

The insurance premiums tax is levied at a rate of 1.5% on all net direct premiums underwritten. The Department of Revenue Services collected $275 million from the insurance premiums tax in FY 25; it is uncertain how much of that revenue is from policies that could be affected by the

[2] Significant uptake of self-funded MEWA trust health benefit plans by small employers currently in the fully insured market could reduce the total amount of net direct written premium that is taxed by the state because self-funded MEWA plans are not an insurance product. However, if the risk pool of the small group fully insured market deteriorates, there would be an offsetting effect in which premiums for the remaining enrollees would rise. Enrollment in the small group market has already been declining in recent years, with some small businesses moving to level-funded plans (which are not part of the fully insured market). Self-funded MEWA trusts are required to purchase certain insurance products (i.e., stop-loss, fiduciary liability, and directors' and officers' liability).

bill.

Significant uptake of the new health plans by businesses and organizations currently in the fully insured small group market could also impact exchange revenue by changing the base for its marketplace assessment beginning in FY 29. The operations of the exchange are almost entirely funded by its marketplace assessments, which are charged at a rate of 1.85% on health and dental premiums in the fully insured individual and small group markets.

The exchange marketplace assessment totaled approximately $36.6 million for FY 25, with small group premiums accounting for 43% of that revenue (approximately $15.8 million annually). For context, fully insured small group plan enrollment was 84,090 in 2023, and 76,047 in 2024.[3]

Insurance Fund Assessments

The bill does not impact the revenue to be collected by the assessments that support the Insurance Fund, except to the extent that more revenue is needed to support DOI costs for regulating self-funded MEWA trusts than what is reimbursed by the entities. Self-funded MEWA trusts would not pay these assessments, premium taxes, or assessments for the Life and Health Insurance Guaranty Association.

[3] Connecticut Insurance Department, 2024 & 2025 Consumer Report Cards on Health Insurance Carriers.

OLR Bill Analysis

sHB 5378

AN ACT CONCERNING SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND REQUIRING A STUDY OF THE FEASIBILITY OF ESTABLISHING THE CONNECTICUT OPTION PROGRAM.

SUMMARY

This bill primarily establishes new requirements for self-funded multiple employer welfare arrangements (MEWAs) and requires a feasibility study for establishing the Connecticut Option Program.

Under the bill, a "self-funded MEWA" is a program established or maintained for employer members to provide health benefit plans for their employees and their dependents that is offered by a self-funded MEWA trust. A "self-funded MEWA trust" is any trust a sponsoring association establishes under the bill's provisions.

Regarding self-funded MEWA trusts, the bill does, among other things, the following :

1. requires them to (a) be licensed and formed by a sponsoring association; (b) maintain specified capital and surplus, reserves, stop-loss and liability insurance, and bonds; and (c) meet coverage and document requirements for health benefit plans they issue (§§ 1-3);

2. requires the Connecticut Insurance Department's (CID) Division of Consumer Affairs to receive and review complaints from Connecticut residents about self-funded MEWA trust-issued health benefit plans, including claims disputes (§ 5);

3. adds self-funded MEWA trusts to the list of companies that the CID commissioner must visit to examine their affairs or carryout market conduct examinations, as he deems expedient (§§ 6 & 7); and

4. authorizes the insurance commissioner to adopt implementing regulations (§ 3).

It also excludes members of an association of small employers from the existing requirement for how premium rates charged or offered by certain plans issued to small employers, must be established (§ 4).

Lastly, it requires the Office of Policy Management (OPM) secretary, in consultation with the insurance commissioner, to study the feasibility of establishing the Connecticut Option Program aimed at reducing health insurance premiums. OPM must report its findings and recommendations to the legislature, by January 15, 2027, for the interim report, and by January 31, 2028, for the final report (§ 8).

EFFECTIVE DATE: January 1, 2027, except the OPM study is effective upon passage.

§§ 2 & 3 — SELF-FUNDED MEWA TRUSTS

Establishing a Self-Funded MEWA Trust (§ 3)

Under the bill, only self-funded MEWA trusts can establish or operate a self-funded MEWA in Connecticut. The bill establishes requirements related to licensure, health benefit plan coverage and documents, a sponsoring association's authority, organizational documents, minimum reserves, stop-loss and liability insurance and bond, board of trustees, and participating employers.

It also specifies that a self-funded MEWA trust is not subject to the Connecticut Insurance Guaranty Association established under existing law to protect insureds when the insurance company has financial difficulty. Existing law requires all insurance companies to be a guaranty association member as a condition of transacting business in Connecticut.

Licensure (§ 3)

Under the bill, a self-funded MEWA trust must apply for and obtain a license from the CID commissioner before establishing a self-funded MEWA in Connecticut. The commissioner must issue a license to the

trust if it satisfies all licensing requirements that apply to health insurance companies under Connecticut's insurance laws.

When the commissioner issues a license to the trust, it must comply with all requirements applicable to health insurance companies under existing insurance laws and regulations.

Starting April 1, 2027, any licensed self-funded MEWA trust may offer a health benefit plan to participating employees of one or more participating employers. A "health benefit plan" is a contract, certificate, or agreement offered, delivered, issued for delivery, renewed, amended, or continued in Connecticut by a self-funded MEWA trust to provide, deliver, arrange for, pay for, or reimburse any of the costs of the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. It does not include insurance products.

Capital and Surplus Requirement. The commissioner requires a self-funded MEWA trust to have an initial combined capital and surplus of (1) at least $4 million dollars or (2) an amount the commissioner determines under the implementing regulations.

Formation of a Self-Funded MEWA Trust by a Sponsoring Association (§ 3)

Under the bill, a sponsoring association must form a self-funded MEWA trust that establishes, maintains, and offers health benefit plans for the self-funded MEWA. The trust must be authorized to sell health benefit plans to participating employers exclusively through licensed insurance producers. The trust must be subject to the federal Employee Retirement Income Security Act (ERISA) and any U.S. Department of Labor (DOL) regulations or standards about MEWAs; and must file a Form M-1 each year with the U.S. DOL.

Under the bill, "Form M-1" is an annual report the U.S. DOL requires for MEWAs that includes: (1) the sponsoring association's and the self-funded MEWA trust's identification; and (2) a description of the health benefit plans the trust offers.

A "sponsoring association" is any industry trade group or other trade group with employer members representing multiple trades domiciled in this state that (1) is organized and has a written constitution or bylaws, (2) has at least 500 employees of at least 25 employer members, and (3) has been maintained in good faith for at least the immediately preceding five years for purposes other than obtaining or providing insurance.

An "employer member" is an entity domiciled in, or has its commercial domicile, in Connecticut and is a member of a sponsoring association and employs more than one individual in Connecticut. It may include the employer member's sponsoring association that is domiciled in Connecticut and employs more than one individual in this state.

Prohibited Use of Certain Words. A self-funded MEWA trust is generally prohibited from including in its name the words "insurance," "insurer," "underwriter," "mutual," or any other word or term or combination of them that describe an insurance company or business. The bill makes an exception if the context indicates that the trust is not an insurance company and is not transacting insurance business.

The trust must also meet other conditions relating to its organizational documents, minimum reserves, certain liability and stop-loss insurance, and bond. These conditions are described below.

Organizational Documents. A self-funded MEWA trust's organizational documents must:

1. state that the trust is sponsored by the sponsoring association;

2. state that the trust's purpose is to provide health benefit plans to eligible employers;

3. provide that the trust's funds are used to benefit eligible employers through (a) self-funding claims or purchasing reinsurance, or a combination of both, and (b) defraying administrative and operating costs and expenses the trust and

any health benefit plan it issues;

4. limit participation in any health benefit plan to eligible employers;

5. establish and maintain a board of trustees, of at least five trustees, that have fiscal control over the trust to manage all health benefit plans established, maintained, and offered by the trust;

6. implement a process to elect trustees to the board; and

7. require each trustee to perform his or her duties based on generally accepted fiduciary standards.

Reserves. The trust must establish and maintain reserves consistent with any state financial and solvency requirements under existing law or regulations applicable to health insurance companies.

Stop-Loss Insurance. The trust must purchase and maintain a stop-loss insurance policy providing coverage for each health benefit plan with retention levels determined consistent with actuarial principles from insurers licensed to transact insurance business in Connecticut.

The trust must purchase and maintain an aggregate stop-loss insurance policy with an attachment point equal to 125% of losses and may submit a written request to the CID commissioner for modification. Within 30 calendar days after receiving the request, the commissioner must issue a decision granting or denying it.

Liability Insurance and Bond Requirement. The bill requires trusts to purchase and maintain commercially reasonable (1) fiduciary liability insurance and (2) directors' and officers' liability insurance. These must be purchased from a Connecticut-licensed insurer.

Trusts must also purchase and maintain a bond in an amount and form the commissioner approves.

Health Benefit Plan Requirements (§ 3)

Under the bill, any health benefit plan a self-funded MEWA trust issues that covers participating employees of one or more participating employers must:

1. provide coverage for essential health benefits according to the federal Patient Protection and Affordable Care Act (ACA);

2. offer each participating employer health benefit plans with a minimum coverage designed to provide health benefits that are actuarially equivalent, respectively, to at least 60%, at least 68%, and at least 78% of the full actuarial value of the benefits provided under each health benefit plan;

3. not limit or exclude coverage for any individual by imposing a preexisting conditions provision (one that limits or excludes based on a condition that was present before the coverage's effective date, but does not include genetic information that is not treated as a condition without a diagnosis of the condition or pregnancy);

4. not set discriminatory rules based on the individual's health status related to health benefit plan eligibility or rate or contribution requirements;

5. set base rates using an actuarially sound, modified community rating methodology that considers pooling all participating employees' claims;

6. use each participating employer's risk profile to set rates by actuarially adjusting above or below established base rates, and using pooling or reinsurance of individual large claims to reduce the adverse impact on any specific participating employer's rates (the trust must set the applicable pooling point, which must consistently apply to all the participating employers);

7. use actuarially sound underwriting methodologies for pricing and renewing health benefit plans for participating employers;

8. adopt and maintain (a) underwriting guidelines to evaluate applicants and accept them as new participating employers and (b) renewal methodologies, which may be reviewed by the commissioner;

9. use surplus above an amount the commissioner sets annually to reduce the health benefit plan contribution amounts participating employers and participating employees pay;

10. make any health benefit plan available to all participating employers regardless of any factor relating to the health status of the participating employer or individuals eligible for coverage through any participating employer; and

11. regarding participating employees, comply with existing notification requirements in existing laws that address utilization review and benefit determinations of a benefit request or claim.

Health Benefit Plan Documents (§ 3)

Documents Issued to Employers. Health benefit plan documents issued by any self-funded MEWA trust to participating employers must have the following statement printed on the first page in 14-point boldface type:

"This health benefit plan is provided by a trust established to provide health benefit plans to employees of employers participating in a self-funded multiple employer welfare arrangement. This health benefit plan is not insurance and is not offered through an insurance company. This health benefit plan 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 participating employer shall be liable for such participating employer's allocated share of the liabilities of the trust under all health benefit plans offered by the trust, as determined by the board of trustees. Each participating employer shall be jointly and severally liable for additional amounts if the annual health benefit plan subscription amounts paid by all participating employers and participating employees of such participating employer

result in a deficit of funds for the trust and for any assessments by state regulators. The trust's financial statements shall be made available upon request by any participating employer in the self-funded multiple employer welfare arrangement."

Documents Issued to Employees. Health benefit plan documents issued by any self-funded MEWA trust to participating employees must have a substantially similar statement printed on it as the bill requires for documents issued to employers, with the addition of information that CID's Consumer Affairs Division is available to help with any questions about the health benefit plan. The notice must also include the division's telephone number and e-mail address.

Board of Trustees (§ 3)

Any board of trustees established under the bill must (1) operate any health benefit plan with the fiduciary standards in the federal Consolidated Appropriations Act and all other generally accepted fiduciary standards; and (2) pay all costs the commissioner assessed under the insurance statutes. The board is authorized to contract with any licensed administrator or service company to administer the health benefit plan's daily operations.

The board of trustees has the authority to collect fees from the participating employers on a pro rata basis. The bill exempts self-funded MEWA trusts from the (1) health and welfare fee assessment, (2) public health fee, (3) taxes or charges imposed on domestic insurers and other entities, and (4) premium taxes imposed on domestic insurance companies.

Participating Employers (§ 3)

Under the bill, each participating employer is (1) liable for its allocated share of the liabilities from a health benefit plan a self-funded MEWA trust provides, as the board of trustee's determines; and (2) jointly and severally liable for additional amounts if the annual health benefit plan subscription amounts all participating employers pay result in a deficit.

The bill prohibits a participating employer's liability from being assessed to the participating employer's participating employees.

§ 5 — CID DIVISION OF CONSUMER AFFAIRS

Complaints

Under current law, CID's Division of Consumer Affairs must receive and review complaints from Connecticut residents related to their insurance problems. The bill expands this to include problems arising out of health benefit plans, including claims disputes.

Quarterly Reports to the Commissioner

Existing law requires the Consumer Affairs Division's director to report to the CID commissioner, the (1) number of complaints the division received the calendar quarter and (2) Connecticut premium volume for each line of insurance company. The bill expands this by requiring the director to also include the premium equivalent volume of a self-funded MEWA trust, against which a complaint has been filed, the types of complaints received, and the number that have been resolved. As under existing law for the insurance information, the reports must be published every six months and copies made available to interested residents upon request. The commissioner must also annually submit the report's findings and any legislative recommendations to address recurring problems to the Insurance and Real Estate Committee by January 15.

§§ 6 & 7 — INSURANCE COMMISSIONER'S OVERSIGHT

Visits and Examinations of Affairs (§ 6)

The bill gives the CID commissioner oversight over self-funded MEWA trusts doing business in Connecticut and requires the commissioner to visit and examine the trusts' affairs at least once every five years, as he is required to do under existing law for insurers doing business in Connecticut.

Market Conduct Examinations (§ 7)

By law, the CID commissioner must make a market conduct examination of regulated entities (insurers, HMOs, third-party

administrators, and fraternal benefit societies doing business in Connecticut) to determine their compliance with applicable state laws and regulations. The bill adds self-funded MEWA trusts to the entities that are subject to the commissioner's market conduct examination and makes corresponding changes to address how these exams are conducted.

As under existing law, the examination must be done according to the National Association of Insurance Commissioners' Market Regulation Handbook. Generally, it is carried out by commissioner-appointed examiners, who (1) examine the company's books, papers, records, or documents, along with information from the officers' and agents' sworn testimony about the company's affairs and (2) report on them to the commissioner. The commissioner may publish the report if he deems it in the public's best interest to do so.

§ 4 — SMALL EMPLOYER ASSOCIATIONS

The law subjects health insurance plans, associations of small employers, and other insurance arrangements covering small employers to certain provisions, such as those related to guarantee issue and renewability.

Under existing law, with respect to plans issued to small employers, the premium rates charged or offered must be set based on a single pool of all grandfathered plans or non-grandfathered plans, as applicable, adjusted to reflect one or more of certain classifications (for example, age, or geographic location). The bill exempts small employers who are members of a small employers association from this requirement.

A "grandfathered plan" is a grandfathered health plan covered by the section of the federal ACA that preserves the right to keep existing coverage.

§ 8 — OPM STUDY OF THE CONNECTICUT OPTION PROGRAM

Connecticut Option Program Study

The bill requires OPM to study the feasibility of establishing the Connecticut Option Program aimed at reducing health insurance

premiums. This program is a standardized health benefit plan designed by the state to lower health care coverage costs and is available through private or commercial insurance carriers to individuals in Connecticut.

A "health benefit plan" under this program is an insurance policy or contract offered, delivered, issued for delivery, renewed, amended, or continued in Connecticut by a health carrier to provide, deliver, pay for, or reimburse health care services costs. Coverage for certain types of benefits is expressly excluded, such as disability, specified accident or accident only, long term care, Medicare or TriCare supplement, travel health, any single service ancillary health (for example, vision, dental, or prescription drug coverage), or certain other limited scope, supplemental, or fixed indemnity benefits.

The study must include enough analysis, conclusions, and recommendations for the OPM secretary, in consultation with the CID commissioner to evaluate and compare design models.

Components of the Study

The bill sets the components of the study and specifies that it must review the efficacy, impact, and reasonableness of proposed program design elements, including,

1. provider reimbursement methodologies;
2. value-based or performance-based contracting arrangements;
3. enrollee cost-sharing and premium affordability targets;
4. incentives or rewards for delivering high-quality, cost-effective health care; and
5. any state-specific premium assistance programs or risk stabilization programs under the ACA.

Under the bill, state-specific premium assistance programs or risk stabilization programs include a state-operated reinsurance program that may maximize available federal funding pursuant to a state

innovation waiver under the ACA. A "state innovation waiver" is a waiver of one or more of the ACA's requirements.

The study must also:

1. identify any statutory or regulatory changes needed for implementation;

2. determine staffing needs across state agencies to effectively implement the program;

3. analyze the state insurance market and the program's projected impact on individuals who get health care coverage through the Connecticut Health Insurance Exchange; and

4. require state action or design elements needed to achieve multiple premium savings targets.

Interim and Final Reports to the Legislature

The OPM secretary must submit to the Appropriations, Human Services, and Insurance and Real Estate committees (1) an interim report by January 15, 2027, and (2) a final report on the program's feasibility and any recommendations on implementing it by January 31, 2028.

Federal Funding. After the study and the reports, if the secretary, in consultation with the commissioner, determines that the program is feasible, then he may direct the relevant state agency to develop and implement any applicable federal waiver, including for the ACA, required to maximize federal funding for the program or any part of it designed to help achieve health care savings.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 9 Nay 4 (03/12/2026)