
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)