



General Assembly

Amendment

February Session, 2026

LCO No. 6190



Offered by:

REP. WOOD K., 29th Dist.
REP. PAVALOCK-D'AMATO, 77th Dist.
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REP. NUCCIO, 53rd Dist.
REP. MESKERS, 150th Dist.

To: Senate Bill No. 342

File No. 223

Cal. No. 575

(As Amended)

"AN ACT CONCERNING HEALTH COVERAGE."

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

3 "Sec. 501. Section 38a-1 of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective January 1, 2027*):

5 Terms used in this title and sections 502 and 503 of this act, unless it
6 appears from the context to the contrary, shall have a scope and
7 meaning as set forth in this section.

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

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

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

20 (4) "Commissioner" means the Insurance Commissioner.

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

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

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

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

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

38 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
39 unable to pay its obligations when they are due, or when its admitted

40 assets do not exceed its liabilities plus the greater of: (A) Capital and
41 surplus required by law for its organization and continued operation;
42 or (B) the total par or stated value of its authorized and issued capital
43 stock. For purposes of this subdivision "liabilities" shall include but not
44 be limited to reserves required by statute or by regulations adopted by
45 the commissioner in accordance with the provisions of chapter 54 or
46 specific requirements imposed by the commissioner upon a subject
47 company at the time of admission or subsequent thereto.

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

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

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

67 (14) "Life insurance" means insurance on human lives and insurances
68 pertaining to or connected with human life. The business of life
69 insurance includes granting endowment benefits, granting additional
70 benefits in the event of death by accident or accidental means, granting
71 additional benefits in the event of the total and permanent disability of

72 the insured, and providing optional methods of settlement of proceeds.
73 Life insurance includes burial contracts to the extent provided by
74 section 38a-464.

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

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

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

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

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

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

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

94 Sec. 502. (NEW) (*Effective January 1, 2027*) For the purposes of this
95 section and section 503 of this act:

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

99 (2) "Commercial domicile" means the headquarters of a trade or

100 business that is the place from which such trade or business is
101 principally managed and directed;

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

108 (4) "ERISA" means the Employee Retirement Income Security Act of
109 1974, as amended from time to time;

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

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

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

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

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

126 (10) "Self-funded multiple employer welfare arrangement" means a
127 program established or maintained on behalf of employer members and
128 offered by a self-funded multiple employer welfare arrangement trust

129 for the purpose of providing one or more health benefit plans for such
130 employer member's employees and such employees' dependents;

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

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

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

145 Sec. 503. (NEW) (*Effective January 1, 2027*) (a) No person, other than a
146 self-funded multiple employer welfare arrangement trust, shall
147 establish or operate a self-funded multiple employer welfare
148 arrangement in this state.

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

160 general statutes and any regulations adopted by the commissioner in
161 accordance with the provisions of chapter 54 of the general statutes.

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

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

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

175 (1) Provide coverage for essential health benefits as defined in the
176 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
177 from time to time, or regulations adopted thereunder;

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

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

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

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

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

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

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

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

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

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

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

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

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

229 (2) A Form M-1 shall be filed each year by such trust with the United
230 States Department of Labor. For purposes of this subdivision, "Form M-
231 1" means an annual report required by the United States Department of
232 Labor for multiple employer welfare arrangements that includes, but is
233 not limited to, the following: (A) Identification of the sponsoring
234 association and the self-funded multiple employer welfare arrangement
235 trust; and (B) a description of the health benefit plans offered through
236 such self-funded multiple employer welfare arrangement trust;

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

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

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

244 (C) Provide that self-funded multiple employer welfare arrangement
245 trust funds shall be used for the benefit of eligible employers through (i)
246 self-funding of claims or the purchase of reinsurance, or any
247 combination thereof, and (ii) defraying the costs and expenses of
248 administering and operating such self-funded multiple employer

249 welfare arrangement trust and any health benefit plan issued by such
250 trust;

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

253 (E) Establish and maintain a board of trustees, composed of not less
254 than five trustees, that shall have fiscal control over such self-funded
255 multiple employer welfare arrangement trust for the purpose of
256 managing all health benefit plans established, maintained and offered
257 by such self-funded multiple employer welfare arrangement trust. Any
258 board of trustees shall have the authority to contract with any licensed
259 administrator or service company to administer the daily operations of
260 the health benefit plans;

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

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

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

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

276 (6) The self-funded multiple employer welfare arrangement trust
277 shall purchase and maintain an aggregate stop-loss insurance policy
278 with an attachment point equal to one hundred twenty-five per cent of

279 losses. The self-funded multiple employer welfare arrangement trust
280 may submit a written request to the commissioner to modify the
281 aggregate stop-loss policy. Not later than thirty calendar days after the
282 commissioner receives such request, the commissioner shall issue a
283 decision granting or denying such request;

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

288 (8) The self-funded multiple employer welfare arrangement trust
289 shall purchase and maintain commercially reasonable directors' and
290 officers' liability insurance from insurers licensed to transact the
291 business of insurance in this state;

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

295 (10) No self-funded multiple employer welfare arrangement trust
296 shall include in its name the words "insurance", "insurer", "underwriter",
297 "mutual" or any other word or term or combination of words or terms
298 that are descriptive of an insurance company or insurance business,
299 unless the context of such words or terms indicates that such self-funded
300 multiple employer welfare arrangement trust is not an insurance
301 company and is not transacting the business of insurance.

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

304 (1) Operate any health benefit plan in accordance with the fiduciary
305 standards set forth in the Consolidated Appropriations Act of 2021, P.L.
306 116-260, as amended from time to time, and all other generally accepted
307 fiduciary standards; and

308 (2) Pay all costs assessed by the commissioner in accordance with title

309 38a of the general statutes. Such board of trustees shall have the
310 authority to collect fees on a pro rata basis from the participating
311 employers. No self-funded multiple employer welfare arrangement
312 trust shall be subject to (A) the health and welfare fee required under
313 section 19a-7j of the general statutes, (B) the public health fee required
314 under section 19a-7p of the general statutes, (C) any payment required
315 under section 38a-48 of the general statutes, or (D) the premium tax
316 required under section 12-202 of the general statutes.

317 (g) Each participating employer shall be (1) liable for such
318 participating employer's allocated share of the liabilities arising under a
319 health benefit plan provided by the self-funded multiple employer
320 welfare arrangement trust, as determined by the board of trustees, and
321 (2) jointly and severally liable for additional amounts if the annual
322 health benefit plan subscription amounts paid by all participating
323 employers of such plan result in a deficit of funds for the self-funded
324 multiple employer welfare arrangement trust. Each participating
325 employer's liability under this subsection shall not be assessed to
326 participating employees of such participating employer.

327 (h) Health benefit plan documents issued by any self-funded multiple
328 employer welfare arrangement trust to participating employers shall
329 have the following statement printed on the first page in fourteen-point
330 boldface type: "This health benefit plan is provided by a trust
331 established to provide health benefit plans to employees of employers
332 participating in a self-funded multiple employer welfare arrangement.
333 This health benefit plan is not insurance and is not offered through an
334 insurance company. This health benefit plan is not required to comply
335 with certain federal market requirements for health insurance, and is
336 not required to comply with certain state laws for health insurance. Each
337 participating employer shall be liable for such participating employer's
338 allocated share of the liabilities of the trust under all health benefit plans
339 offered by the trust, as determined by the board of trustees. Each
340 participating employer shall be jointly and severally liable for additional
341 amounts if the annual health benefit plan subscription amounts paid by

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

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

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

374 (k) The commissioner may adopt regulations, in accordance with the

375 provisions of chapter 54 of the general statutes, to implement the
376 provisions of this section.

377 Sec. 504. Section 38a-567 of the general statutes is repealed and the
378 following is substituted in lieu thereof (*Effective January 1, 2027*):

379 Health insurance plans, associations of small employers and other
380 insurance arrangements covering small employers and insurers and
381 producers marketing such plans and arrangements shall be subject to
382 the following provisions:

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

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

401 (C) Renewability of coverage may be effected by either continuing in
402 effect a plan or arrangement covering a small employer or by
403 substituting upon renewal for the prior plan or arrangement the plan or
404 arrangement then offered by the carrier that most closely corresponds
405 to the prior plan or arrangement and is available to other small

406 employers. Such substitution shall only be made under conditions
407 approved by the commissioner. A carrier may substitute a plan or
408 arrangement as set forth in this subparagraph only if the carrier effects
409 the same substitution upon renewal for all small employers previously
410 covered under the particular plan or arrangement, unless otherwise
411 approved by the commissioner. The substitute plan or arrangement
412 shall be subject to the rating restrictions specified in this section on the
413 same basis as if no substitution had occurred, except for an adjustment
414 based on coverage differences.

415 (D) Any such plan or arrangement shall provide special enrollment
416 periods (i) to all eligible employees or dependents as set forth in 45 CFR
417 147.104, as amended from time to time, and (ii) for coverage under such
418 plan or arrangement ordered by a court for a spouse or minor child of
419 an eligible employee where request for enrollment is made not later than
420 thirty days after the issuance of such court order.

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

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

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

432 (ii) Gender;

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

435 (iv) Industry, provided the rate factor associated with any industry

436 classification shall not vary from the arithmetic average of the highest
437 and lowest rate factors associated with all industry classifications by
438 greater than fifteen per cent of such average, and provided further, the
439 rate factors associated with any industry shall not be increased by more
440 than five per cent per year;

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

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

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

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

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

466 (I) Age, in accordance with a uniform age rating curve established by

467 the commissioner; or

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

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

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

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

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

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

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

496 (4) No small employer carrier shall, directly or indirectly, enter into
497 any contract, agreement or arrangement with a producer that provides
498 for or results in the compensation paid to a producer for the sale of a
499 health benefit plan to be varied because of the health status, claims
500 experience, industry, occupation or geographic area of the small
501 employer. A small employer carrier shall provide reasonable
502 compensation, as provided under the plan of operation of the program,
503 to a producer, if any, for the sale of a health care plan. No small
504 employer carrier shall terminate, fail to renew or limit its contract or
505 agreement of representation with a producer for any reason related to
506 the health status, claims experience, occupation, or geographic location
507 of the small employers placed by the producer with the small employer
508 carrier.

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

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

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

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

527 (9) Any violation of subdivisions (3) to (7), inclusive, of this section
528 and of any regulations established under subdivision (8) of this section
529 shall be an unfair and prohibited practice under sections 38a-815 to 38a-
530 830, inclusive.

531 Sec. 505. Subsection (a) of section 38a-9 of the 2026 supplement to the
532 general statutes is repealed and the following is substituted in lieu
533 thereof (*Effective January 1, 2027*):

534 (a) Notwithstanding the provisions of section 4-8, there shall be a
535 Division of Consumer Affairs within the Insurance Department, which
536 division shall act on the Insurance Commissioner's behalf and at his
537 direction in order to carry out his responsibilities under this title with
538 respect to such matters. The division shall receive and review
539 complaints from residents of this state concerning their insurance
540 problems and problems arising out of health benefit plans, as defined in
541 section 502 of this act, including claims disputes, and serve as a mediator
542 in such disputes in order to assist the commissioner in determining
543 whether statutory requirements and contractual obligations within the
544 commissioner's jurisdiction have been fulfilled. There shall be a director
545 of said division, who shall be provided with sufficient staff. The division
546 shall serve to coordinate all appropriate facilities in the department in
547 addressing such complaints, and conduct any outreach programs
548 deemed necessary to properly inform and educate the public on
549 insurance matters. The director shall submit quarterly reports to the
550 commissioner, which shall state the number of complaints received by
551 the division in such calendar quarter, the Connecticut premium or
552 premium equivalent volume of the appropriate line of each insurance
553 company or self-funded multiple employer welfare arrangement trust,
554 as defined in section 502 of this act, against which a complaint has been
555 filed, the types of complaints received, and the number of such
556 complaints which have been resolved. Such reports shall be published
557 every six months and copies shall be made available to any interested
558 resident of this state upon request. The commissioner shall report, in
559 accordance with section 11-4a, to the joint standing committee of the

560 General Assembly having cognizance of matters relating to insurance
561 on or before January fifteenth annually, concerning the findings of such
562 reports and suggestions for legislative initiatives to address recurring
563 problems.

564 Sec. 506. Section 38a-14 of the general statutes is repealed and the
565 following is substituted in lieu thereof (*Effective January 1, 2027*):

566 (a) For the purposes of this section, "company" means any insurance
567 company, self-funded multiple employer welfare arrangement trust, as
568 defined in section 502 of this act, or health care center doing business in
569 this state, any corporation or association collecting data utilized by any
570 such insurance company in the underwriting of insurance policies and
571 any corporation organized under any law of this state or having an
572 office in this state, which corporation is engaged in, or claiming or
573 advertising that it is engaged in, organizing or receiving subscriptions
574 for or disposing of stock of, or in any manner aiding or taking part in
575 the formation or business of, an insurance company or companies, or
576 that is holding the capital stock of one or more insurance corporations
577 for the purpose of controlling the management thereof, as voting
578 trustees or otherwise.

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

588 (c) (1) To carry out examinations under this section, the commissioner
589 may appoint one or more competent persons as examiners, who shall
590 not be officers of, connected with or interested in any company, other
591 than as policyholders. The commissioner may engage the services of

592 attorneys, appraisers, independent actuaries, independent certified
593 public accountants or other professionals and specialists as examiners
594 to assist the commissioner in conducting the examinations under this
595 section, the cost of which shall be borne by the company that is the
596 subject of the examination.

597 (2) In conducting the examination, the commissioner, the
598 commissioner's actuary or any examiner authorized by the
599 commissioner may examine, under oath, the officers and agents of such
600 a company, and all persons deemed to have material information
601 regarding the company's property or business. Each such company or
602 its officers and agents shall produce the books and papers in its or their
603 possession, relating to its business or affairs, and any other person may
604 be required to produce any book or paper in such person's custody that
605 is deemed to be relevant to such examination, for inspection by the
606 commissioner, the commissioner's actuary or examiners. The officers
607 and agents of the company shall facilitate the examination and aid the
608 examiners in making the same so far as it is in their power to do so. The
609 refusal of any company, by its officers, directors, employees or agents,
610 to submit to examination or to comply with any reasonable written
611 request of the examiners shall be grounds for suspension of, refusal of
612 or nonrenewal of any license or authority held by the company to
613 engage in an insurance or other business subject to the commissioner's
614 jurisdiction. Any such proceedings for suspension, revocation or refusal
615 of any license or authority shall be conducted pursuant to subsection (c)
616 of section 38a-41.

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

622 (d) In lieu of an examination under this section of any foreign or alien
623 insurer licensed in this state, the commissioner may accept an
624 examination report on such insurer prepared by the insurance

625 department for the insurer's state of domicile or port-of-entry state if (1)
626 such state's insurance department was, at the time of the examination,
627 accredited under the National Association of Insurance Commissioners'
628 financial regulation standards and accreditation program, or (2) the
629 examination is performed under the supervision of an accredited
630 insurance department or with the participation of one or more
631 examiners who are employed by such an accredited state insurance
632 department and who, after a review of the examination workpapers and
633 report, state under oath that the examination was performed in a
634 manner consistent with the standards and procedures required by their
635 insurance department.

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

642 (2) Nothing contained in this section shall be construed to limit the
643 commissioner's authority in such legal or regulatory action to use and,
644 if appropriate, to make public any final or preliminary examination
645 report, any examiner or company workpapers or other documents, or
646 any other information discovered or developed during the course of any
647 examination.

648 (3) Not later than sixty days following completion of the examination,
649 the examiner in charge shall file, under oath, with the Insurance
650 Department a verified written report of examination. Upon receipt of
651 the verified report, the Insurance Department shall transmit the report
652 to the company examined, together with a notice that shall afford the
653 company examined a reasonable opportunity, not to exceed thirty days,
654 to make a written submission or rebuttal with respect to any matters
655 contained in the examination report. Not later than thirty days after the
656 period allowed for the receipt of written submissions or rebuttals, the
657 commissioner shall fully consider and review the report, together with

658 any written submissions or rebuttals and any relevant portions of the
659 examiner's workpapers and enter an order: (A) Adopting the
660 examination report as filed or with modification or corrections. If the
661 examination report reveals that the company is operating in violation of
662 any law, regulation or prior order of the commissioner, the
663 commissioner may order the company to take any action the
664 commissioner considers necessary and appropriate to cure such
665 violation; (B) rejecting the examination report with directions to the
666 examiners to reopen the examination for purposes of obtaining
667 additional data, documentation or information, and refiling pursuant to
668 this subdivision; or (C) calling for an investigatory hearing with not less
669 than twenty days' notice to the company for purposes of obtaining
670 additional documentation, data, information and testimony.

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

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

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

691 provided in section 38a-19.

692 (2) Any investigatory hearing conducted under subparagraph (C) of
693 subdivision (3) of subsection (e) of this section by the commissioner or
694 the commissioner's authorized representative, shall be conducted as a
695 nonadversarial confidential investigatory proceeding as necessary for
696 the resolution of any inconsistencies, discrepancies or disputed issues
697 apparent (A) upon the filed examination report, (B) raised by or as a
698 result of the commissioner's review of relevant workpapers, or (C) by
699 the written submission or rebuttal of the company. Not later than
700 twenty days after the conclusion of any such hearing, the commissioner
701 shall enter an order pursuant to subparagraph (A) of subdivision (3) of
702 subsection (e) of this section. The commissioner shall not appoint an
703 examiner as an authorized representative to conduct the hearing. The
704 hearing shall proceed expeditiously with discovery by the company
705 limited to the examiner's workpapers that tend to substantiate any
706 assertions set forth in any written submission or rebuttal. The
707 commissioner or the commissioner's authorized representative may
708 issue subpoenas for the attendance of any witnesses or the production
709 of any documents deemed relevant to the investigation, whether under
710 the control of the department, the company or other persons. The
711 documents produced shall be included in the record and testimony
712 taken by the commissioner or the commissioner's authorized
713 representative shall be under oath and preserved for the record.
714 Nothing contained in this section shall require the department to
715 disclose any information or records that would indicate or show the
716 existence or content of any investigation or activity of a criminal justice
717 agency. The hearing shall proceed with the commissioner or the
718 commissioner's authorized representative posing questions to the
719 persons subpoenaed. Thereafter, the company and the Insurance
720 Department may present testimony relevant to the investigation. Cross-
721 examination shall be conducted only by the commissioner or the
722 commissioner's authorized representative. The company and the
723 Insurance Department shall be permitted to make closing statements
724 and may be represented by counsel of their choice.

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

728 (h) The commissioner shall, at least once in every five years, visit and
729 examine the affairs of each domestic insurer, domestic health care
730 center, domestic fraternal benefit society, self-funded multiple
731 employer welfare arrangement trust, as defined in section 502 of this act,
732 and foreign and alien insurer doing business in this state.
733 Notwithstanding subdivision (1) of subsection (c) of this section, no
734 domestic insurer or such other domestic entity subject to examination
735 under this section shall pay as costs associated with the examination the
736 salaries, fringe benefits or travel and maintenance expenses of
737 examining personnel of the Insurance Department engaged in such
738 examination if such domestic insurer or domestic entity is otherwise
739 liable to assessment levied under section 38a-47, except that a domestic
740 insurer or such other domestic entity shall pay the travel and
741 maintenance expenses of examining personnel of the Insurance
742 Department when such insurer or entity is examined outside the state.

743 (i) Nothing contained in this section shall prevent or be construed as
744 prohibiting the commissioner from disclosing the content of an
745 examination report, preliminary examination report or results, or any
746 matter relating thereto, to the Insurance Department of this or any other
747 state or country, or to law enforcement officials of this or any other state
748 or to any agency of the federal government at any time, so long as such
749 agency or office receiving the report or matters relating thereto agrees,
750 in writing, to hold such report and matters relating thereto confidential.

751 (j) All workpapers, recorded information, documents and copies
752 thereof produced by, obtained by or disclosed to the commissioner or
753 any other person in the course of an examination made under this
754 section shall be confidential, shall not be subject to subpoena and shall
755 not be made public by the commissioner or any other person, except to
756 the extent provided in subsection (i) of this section. The commissioner
757 may grant access to such workpapers, recorded information, documents

758 and copies thereof to the National Association of Insurance
759 Commissioners, provided said association agrees, in writing, to hold
760 such workpapers, recorded information, documents and copies thereof
761 confidential.

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

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

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

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

783 (5) A person identified in subdivision (2) of this subsection shall be
784 entitled to an award of attorney's fees and costs if such person is the
785 prevailing party in a civil action for libel, slander or any other relevant
786 tort arising out of activities in carrying out the provisions of this section
787 and the party bringing the action was not substantially justified in doing
788 so. For purposes of this section, a proceeding is "substantially justified"

789 if it had a reasonable basis in law or fact at the time that it was initiated.

790 Sec. 507. Section 38a-15 of the general statutes is repealed and the
791 following is substituted in lieu thereof (*Effective January 1, 2027*):

792 (a) The commissioner shall, as often as the commissioner deems it
793 expedient, undertake a market conduct examination of the affairs of any
794 insurance company, health care center, self-funded multiple employer
795 welfare arrangement trust, as defined in section 502 of this act, third-
796 party administrator, as defined in section 38a-720, or fraternal benefit
797 society doing business in this state. Any such examination may be
798 conducted in accordance with the procedures and definitions set forth
799 in the National Association of Insurance Commissioners' Market
800 Regulation Handbook.

801 (b) To carry out the examinations under this section, the
802 commissioner may appoint, as market conduct examiners, one or more
803 competent persons, who shall not be officers of, or connected with or
804 interested in, any insurance company, health care center, self-funded
805 multiple employer welfare arrangement trust, third-party administrator
806 or fraternal benefit society, other than as a policyholder. In conducting
807 the examination, the commissioner, the commissioner's actuary or any
808 examiner authorized by the commissioner may examine, under oath,
809 the officers and agents of such insurance company, health care center,
810 self-funded multiple employer welfare arrangement trust, third-party
811 administrator or fraternal benefit society and all persons deemed to
812 have material information regarding the company's, center's, self-
813 funded multiple employer welfare arrangement trust's, administrator's
814 or society's property or business. Each such company, center, self-
815 funded multiple employer welfare arrangement trust, administrator or
816 society, its officers and agents, shall produce the books and papers, in
817 its or their possession, relating to its business or affairs, and any other
818 person may be required to produce any book or paper in such person's
819 custody, deemed to be relevant to the examination, for the inspection of
820 the commissioner, the commissioner's actuary or examiners, when
821 required. The officers and agents of the company, center, self-funded

822 multiple employer welfare arrangement trust, administrator or society
823 shall facilitate the examination and aid the examiners in making the
824 same so far as it is in their power to do so.

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

843 (d) (1) All the expense of any examination made under the authority
844 of this section, other than examinations of domestic insurance
845 companies and domestic health care centers, shall be paid by the
846 company, center, self-funded multiple employer welfare arrangement
847 trust, administrator or society examined.

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

855 companies and domestic health care centers examined outside the state
856 shall pay the travel and maintenance expenses of such examining
857 personnel.

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

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

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

873 (f) Nothing in this section shall be construed to prevent or prohibit
874 the commissioner from disclosing at any time the content or results of
875 an examination report or a preliminary examination report or any
876 matter relating to such report, to (1) the insurance regulatory officials of
877 this state or any other state or country, (2) law enforcement officials of
878 this or any other state, or (3) any agency of this or any other state or of
879 the federal government, provided such officials or agency receiving the
880 report or matters relating to the report agrees, in writing, to hold such
881 report or matters confidential.

882 (g) All workpapers, recorded information, documents and copies
883 thereof produced by, obtained by or disclosed to the commissioner or
884 any other person in the course of an examination made under the
885 authority of this section shall be confidential, shall not be subject to

886 subpoena and shall not be made public by the commissioner or any
887 other person, except to the extent provided in subsection (f) of this
888 section. The commissioner may grant access to such workpapers,
889 recorded information, documents and copies to the National
890 Association of Insurance Commissioners, provided said association
891 agrees, in writing, to hold such workpapers, recorded information,
892 documents and copies thereof confidential."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	<i>January 1, 2027</i>	38a-1
Sec. 502	<i>January 1, 2027</i>	New section
Sec. 503	<i>January 1, 2027</i>	New section
Sec. 504	<i>January 1, 2027</i>	38a-567
Sec. 505	<i>January 1, 2027</i>	38a-9(a)
Sec. 506	<i>January 1, 2027</i>	38a-14
Sec. 507	<i>January 1, 2027</i>	38a-15