General Assembly

Amendment

February Session, 2024

LCO No. **5377**

Offered by:
REP. WOOD K., 29th Dist.
REP. PAVALOCK-D'AMATO, 77th Dist.

To: Subst. House Bill No. **5503** File No. 644 Cal. No. 253

"AN ACT CONCERNING INSURANCE MARKET CONDUCT AND INSURANCE LICENSING, THE INSURANCE DEPARTMENT'S TECHNICAL CORRECTIONS AND OTHER REVISIONS TO THE INSURANCE STATUTES AND CAPTIVE INSURANCE."

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

"Section 1. Subsection (a) of section 38a-8 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) The commissioner shall see that all laws respecting insurance companies and health care centers are faithfully executed and shall administer and enforce the provisions of this title. The commissioner shall have all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to protect the public interest in accordance with the duties imposed by this title, including, but not limited to, the power to order restitution of any sums

obtained in violation of any provision of this title, or any regulation or order adopted or issued pursuant to this title by the commissioner, plus interest at the rate set forth in section 37-3a. The commissioner shall pay to the Treasurer all the fees that the commissioner receives. The commissioner may administer oaths in the discharge of the commissioner's duties.

Sec. 2. Section 38a-702k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) The commissioner may place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or may levy a civil penalty in accordance with the provisions of this title, or may take any combination of such actions, for any one or more of the following causes: (1) Providing incorrect, misleading, incomplete or materially untrue information in the license application; (2) violating any insurance laws, or violating any regulation, subpoena or order of the commissioner or of another state's commissioner; (3) obtaining or attempting to obtain a license through misrepresentation or fraud; (4) improperly withholding, misappropriating or converting any moneys or properties received in the course of doing an insurance business; (5) intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance; (6) having been convicted of a felony; (7) having admitted or been found to have committed any insurance unfair trade practice or fraud; (8) using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere; (9) having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory; (10) forging another's name to an application for insurance or to any document related to an insurance transaction; (11) improperly using notes or any other reference material to complete an examination for an insurance license; (12) knowingly accepting insurance business from an individual who is not licensed; (13) failing to comply with an administrative or court order imposing a child support obligation; or (14) failing to pay state income tax or

comply with any administrative or court order directing payment of state income tax.

(b) If the action by the commissioner is to nonrenew a license or to deny an application for a license, the commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the commissioner, not later than thirty days after the notice, for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held not later than twenty days after receipt of such request and shall be held pursuant to section 38a-19.

(c) The license of a business entity may be suspended, revoked or refused if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the commissioner nor corrective action taken.

(d) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine pursuant to section 38a-774.

(e) The commissioner shall retain the authority to enforce the provisions of, and impose any penalty or remedy authorized by, this title against any person who is under investigation for or charged with a violation of this title even if the person's license or registration has been surrendered, revoked or has lapsed by operation of law.

(f) Unless otherwise provided in the provisions of this title, the Attorney General may, at the request of the commissioner, apply to the Superior Court for an order: (1) Temporarily or permanently restraining and enjoining any person from violating any provision of this title, (2) enforcing any order, penalty or remedy imposed by the commissioner, or (3) providing restitution against any person for any sums shown by

the commissioner to have been obtained by such person in violation of any such provision of this title.

Sec. 3. Section 38a-16 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) (1) The Insurance Commissioner or the commissioner's authorized representative may, as often as the commissioner deems necessary, conduct investigations and hearings in aid of any investigation on any matter under the provisions of this title. Pursuant to any such investigation or hearing, the commissioner or the commissioner's authorized representative may issue data calls, subpoenas, administer oaths, compel testimony, order the production of books, records, papers and documents, and examine books and records. Any person in receipt of an order from the commissioner or the commissioner's authorized representative for the production of books, records, papers or documents shall comply with the order not later than thirty calendar days after the date of such order. If any person refuses to allow the examination of books and records, to appear, to testify or to produce any book, record, paper or document when so ordered, a judge of the Superior Court, upon application of the commissioner or the commissioner's authorized representative, may make such order as may be appropriate to aid in the enforcement of this section.

(2) Data provided in response to a data call under this section shall not be subject to disclosure under section 1-210.

(b) The Attorney General, at the request of the commissioner, is authorized to apply in the name of the state of Connecticut to the Superior Court for an order temporarily or permanently restraining and enjoining any person from violating any provision of this title.

Sec. 4. Subsection (a) of section 38a-790 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) No person shall act as an appraiser for motor vehicle physical

damage claims on behalf of any insurance company or firm or corporation engaged in the adjustment or appraisal of motor vehicle claims unless such person has first secured a license from the Insurance Commissioner, and has paid the license fee specified in section 38a-11, for each two-year period or fraction thereof. The license shall be applied for as provided in section 38a-769. The commissioner may waive the requirement for examination in the case of any applicant for a motor vehicle physical damage appraiser's license who is a nonresident of this state and who holds an equivalent license from any other state. Any **[**such license issued by the commissioner shall be in force until the thirtieth day of June in each odd-numbered year**]** initial license issued by the commissioner to an appraiser for motor vehicle physical damage claims shall expire two years after the date of the licensee's birthday that preceded the date the license was issued unless sooner revoked or suspended. The license may, in the discretion of the commissioner, be renewed biennially upon payment of the fee specified in section 38a-11. The commissioner may adopt reasonable regulations concerning standards for qualification, suspension or revocation of such licenses and the methods by which licensees shall conduct their business.

Sec. 5. Subsection (a) of section 38a-792 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) (1) No person may act as an adjuster of casualty claims for any insurance company or firm or corporation engaged in the adjustment of casualty claims unless such person has first secured a license from the commissioner, and has paid the license fee specified in section 38a-11, for each two-year period or fraction thereof. Application for such license shall be made as provided in section 38a-769. Any **[**such license issued by the commissioner shall be in force until June thirtieth in each odd-numbered year**]** initial license issued to an adjuster of casualty claims shall expire two years after the date of the licensee's birthday that preceded the date the license was issued unless sooner revoked or suspended. The **[**person**]** licensee may, at the discretion of the commissioner, renew the license biennially thereafter upon payment of

the fee specified in section 38a-11.

(2) The commissioner may waive the examination required under section 38a-769, in the case of any applicant for a casualty claims adjuster's license that (A) is a nonresident of this state or has its principal place of business in another state, and holds an equivalent license from any other state, or (B) at any time within two years next preceding the date of application has been licensed in this state under a license of the same type as the license applied for.

Sec. 6. Section 38a-48 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) On or before June thirtieth, annually, the Commissioner of Revenue Services shall render to the Insurance Commissioner a statement certifying the amount of taxes or charges imposed on each domestic insurance company or other domestic entity under chapter 207 on business done in this state during the preceding calendar year. The statement for local domestic insurance companies shall set forth the amount of taxes and charges before any tax credits allowed as provided in subsection (a) of section 12-202.

(b) On or before July thirty-first, annually, the Insurance Commissioner **[**and the Office of the Healthcare Advocate**]** shall render to each domestic insurance company or other domestic entity liable for payment under section 38a-47: (1) A statement that includes (A) the amount appropriated to the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund established under section 38a-52a for the fiscal year beginning July first of the same year, (B) the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, (C) the estimated expenditures on behalf of the department and the offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, not including such estimated expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and (D) the amount appropriated to the

Department of Aging and Disability Services for the fall prevention program established in section 17a-859 from the Insurance Fund for the fiscal year; (2) a statement of the total taxes imposed on all domestic insurance companies and domestic insurance entities under chapter 207 on business done in this state during the preceding calendar year; and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided for the purposes of this calculation the amount appropriated to the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund plus the cost of fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and **[**the office**]** such offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy shall be deemed to be the actual expenditures of the department and **[**the office**]** such offices, and the amount appropriated to the Department of Aging and Disability Services from the Insurance Fund for the fiscal year for the fall prevention program established in section 17a-859 shall be deemed to be the actual expenditures for the program.

(c) (1) The proposed assessments for each domestic insurance company or other domestic entity shall be calculated by (A) allocating twenty per cent of the amount to be paid under section 38a-47 among the domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such entities on business done in this state during the preceding calendar year, and (B) allocating eighty per cent of the amount to be paid under section 38a-47 among all domestic insurance companies and domestic entities other than those organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such domestic insurance companies and domestic entities on business done in this state during the preceding calendar

year, provided if there are no domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of assessment, one hundred per cent of the amount to be paid under section 38a-47 shall be allocated among such domestic insurance companies and domestic entities.

(2) When the amount any such company or entity is assessed pursuant to this section exceeds twenty-five per cent of the actual expenditures of the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund, such excess amount shall not be paid by such company or entity but rather shall be assessed against and paid by all other such companies and entities in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on business done in this state during the preceding calendar year, except that for purposes of any assessment made to fund payments to the Department of Public Health to purchase vaccines, such company or entity shall be responsible for its share of the costs, notwithstanding whether its assessment exceeds twenty-five per cent of the actual expenditures of the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund. The provisions of this subdivision shall not be applicable to any corporation **[**which**]** that has converted to a domestic mutual insurance company pursuant to section 38a-155 upon the effective date of any public act **[**which**]** that amends said section to modify or remove any restriction on the business such a company may engage in, for purposes of any assessment due from such company on and after such effective date.

(d) For purposes of calculating the amount of payment under section 38a-47, as well as the amount of the assessments under this section, the "total taxes imposed on all domestic insurance companies and other domestic entities under chapter 207" shall be based upon the amounts shown as payable to the state for the calendar year on the returns filed with the Commissioner of Revenue Services pursuant to chapter 207; with respect to calculating the amount of payment and assessment for local domestic insurance companies, the amount used shall be the taxes

and charges imposed before any tax credits allowed as provided in subsection (a) of section 12-202.

[(e) On or before September thirtieth, annually, for each fiscal year ending prior to July 1, 1990, the Insurance Commissioner and the Healthcare Advocate, after receiving any objections to the proposed assessments and making such adjustments as in their opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before October thirty-first an amount equal to fifty per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (g) of this section. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before the following April thirtieth, the remaining fifty per cent of its assessment.**]**

[(f)**]** (e) On or before September first, annually, for each fiscal year, **[**ending after July 1, 1990,**]** the Insurance Commissioner, **[**and the Healthcare Advocate,**]** after receiving any objections to the proposed assessments and making such adjustments as in **[**their**]** the commissioner's opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner (1) **[**on or before June 30, 1990, and**]** on or before June thirtieth, annually, **[**thereafter,**]** an estimated payment against its assessment for the following year equal to twenty-five per cent of its assessment for the fiscal year ending such June thirtieth, (2) on or before September thirtieth, annually, twenty-five per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection **[**(g)**]** (f) of this section, and (3) on or before the following December thirty-first and March thirty-first, annually, each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner the remaining

fifty per cent of its proposed assessment to the department in two equal installments.

[(g)**]** (f) If the actual expenditures for the fall prevention program established in section 17a-859 are less than the amount allocated, the Commissioner of Aging and Disability Services shall notify the Insurance Commissioner. **[**and the Healthcare Advocate.**]** Immediately following the close of the fiscal year, the Insurance Commissioner **[**and the Healthcare Advocate**]** shall recalculate the proposed assessment for each domestic insurance company or other domestic entity in accordance with subsection (c) of this section using the actual expenditures made during the fiscal year by the Insurance Department, the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund, the actual expenditures made on behalf of the department and the offices from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and the actual expenditures for the fall prevention program. On or before July thirty-first, annually, the Insurance Commissioner **[**and the Healthcare Advocate**]** shall render to each such domestic insurance company and other domestic entity a statement showing the difference between their respective recalculated assessments and the amount they have previously paid. On or before August thirty-first, the Insurance Commissioner, **[**and the Healthcare Advocate,**]** after receiving any objections to such statements, shall make such adjustments which in their opinion may be indicated, and shall render an adjusted assessment, if any, to the affected companies. Any such domestic insurance company or other domestic entity may pay to the Insurance Commissioner the entire assessment required under this subsection in one payment when the first installment of such assessment is due.

[(h)**]** (g) If any assessment is not paid when due, a penalty of twenty-five dollars shall be added thereto, and interest at the rate of six per cent per annum shall be paid thereafter on such assessment and penalty.

[(i)**]** (h) The Insurance Commissioner shall deposit all payments made under this section with the State Treasurer. On and after June 6, 1991, the moneys so deposited shall be credited to the Insurance Fund established under section 38a-52a and shall be accounted for as expenses recovered from insurance companies.

Sec. 7. Subsection (a) of section 38a-53 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) (1) Each domestic insurance company or domestic health care center shall, annually, on or before the first day of March, submit to the commissioner, **[**and**]** by electronically **[**to**]** filing with the National Association of Insurance Commissioners, a true and complete report, signed and sworn to by its president or a vice president, and secretary or an assistant secretary, of its financial condition on the thirty-first day of December next preceding, prepared in accordance with the National Association of Insurance Commissioners annual statement instructions handbook and following those accounting procedures and practices prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual, subject to any deviations in form and detail as may be prescribed by the commissioner. An electronically filed report in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall **[**not exempt a domestic insurance company or domestic health care center from timely filing a true and complete paper copy with the commissioner**]** be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

(2) Each accredited reinsurer, as defined in subdivision (1) of subsection (c) of section 38a-85, and assuming insurance company, as provided in section 38a-85, shall file an annual report in accordance with the provisions of section 38a-85.

Sec. 8. Subsection (a) of section 38a-54 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October*

1, 2024):

(a) Each domestic insurance company, domestic health care center or domestic fraternal benefit society doing business in this state shall have an annual audit conducted by an independent certified public accountant and shall annually file an audited financial report with the commissioner, and electronically to the National Association of Insurance Commissioners on or before the first day of June for the year ending the preceding December thirty-first. An electronically filed true and complete report timely submitted to the National Association of Insurance Commissioners **[**does not exempt a domestic insurance company or a domestic health care center from timely filing a true and complete paper copy to the commissioner**]** shall be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

Sec. 9. Section 38a-297 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(a) For the purposes of sections 38a-295 to 38a-300, inclusive, a policy shall be deemed readable if: (1) The text achieves a minimum score of forty-five on the Flesch reading ease test as computed in section 38a-298 or an equivalent score on any other test comparable in result and approved by the commissioner, (2) it is printed, except for specification pages, schedules and tables, in not less than ten-point type, one-point leaded, of a height and style specified by the commissioner in regulations adopted in accordance with the provisions of chapter 54, (3) it uses layout and spacing which separate the paragraphs from each other and from the border of the paper, (4) it has section titles captioned in boldface type or which otherwise stand out significantly from the text, (5) it avoids the use of unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions, (6) the style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders and (7) it contains a table of contents or an index of the principal sections of the policy, if the policy has more than three

thousand words or if the policy has more than three pages. To be deemed readable, each policy of individual health insurance shall include a separate outline of coverage showing the major coverage, benefit, exclusion and renewal provisions of the policy in readily understandable terms, provided the policy shall take precedence over the outline of coverage.

(b) The commissioner may authorize a lower score than the Flesch reading ease score required in subsection (a) whenever **[**he**]** the commissioner finds that a lower score (1) will provide a more accurate reflection of the readability of a policy form; (2) is warranted by the nature of a particular policy form or type or class of policy forms; or (3) is the result of language which is used to conform to the requirements of any state or federal law, regulation or governmental agency.

(c) Filings subject to this section shall be accompanied by a certification signed by an officer of the insurer stating that it meets the requirements of subsection (a) of this section. Such certification shall state that the policy meets the minimum reading ease score on the test used or that the score is lower than the minimum required but should be approved in accordance with subsection (b) of this section. The commissioner may require the submission of further information to verify any certification.

(d) Filings subject to this section may be filed with the commissioner in any language. Any non-English-language policy shall be deemed to be in compliance with subsection (a) of this section if the insurer certifies that such policy **[**is translated from an English-language policy that**]** complies with **[**said**]** subsection (a) of this section or is translated from a policy that complies with subsection (a) of this section.

(e) The commissioner may engage the services of any translation service, as needed, to review any non-English-language policy filed with the commissioner pursuant to this section, the cost of which shall be borne by the insurer that submits such filing.

(f) (1) For any insurer that files a non-English-language policy with

the commissioner, the commissioner may require that such insurer either (A) provide an English translated copy of such policy and a certification as to the accuracy of such translated copy of such policy, or (B) pay all costs associated with the translation of such policy in accordance with the provisions of subsection (e) of this section.

(2) Any insurer shall accept all risk associated with any translation of such insurer's non-English-language policy in accordance with subdivision (1) of this subsection and subsection (e) of this section.

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

Sec. 10. Section 38a-479ppp of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2025*):

(a) Not later than **[**March 1, 2021**]** February 1, 2025, and annually thereafter, each pharmacy benefits manager shall file a report with the commissioner for the immediately preceding calendar year. The report shall contain the following information for health carriers that delivered, issued for delivery, renewed, amended or continued health care plans that included a pharmacy benefit managed by the pharmacy benefits manager during such calendar year:

(1) The aggregate dollar amount of all rebates concerning drug formularies used by such health carriers that such manager collected from pharmaceutical manufacturers that manufactured outpatient prescription drugs that (A) were covered by such health carriers during such calendar year, and (B) are attributable to patient utilization of such drugs during such calendar year; and

(2) The aggregate dollar amount of all rebates, excluding any portion of the rebates received by such health carriers, concerning drug formularies that such manager collected from pharmaceutical manufacturers that manufactured outpatient prescription drugs that (A) were covered by such health carriers during such calendar year, and (B) are attributable to patient utilization of such drugs by covered persons

under such health care plans during such calendar year.

(b) The commissioner shall establish a standardized form for reporting information pursuant to subsection (a) of this section after consultation with pharmacy benefits managers. The form shall be designed to minimize the administrative burden and cost of reporting on the department and pharmacy benefits managers.

(c) All information submitted to the commissioner pursuant to subsection (a) of this section shall be exempt from disclosure under the Freedom of Information Act, as defined in section 1-200, except to the extent such information is included on an aggregated basis in the report required by subsection (d) of this section. The commissioner shall not disclose information submitted pursuant to subdivision (1) of subsection (a) of this section, or information submitted pursuant to subdivision (2) of said subsection in a manner that (1) is likely to compromise the financial, competitive or proprietary nature of such information, or (2) would enable a third party to identify a health care plan, health carrier, pharmacy benefits manager, pharmaceutical manufacturer, or the value of a rebate provided for a particular outpatient prescription drug or therapeutic class of outpatient prescription drugs.

(d) Not later than **[**March 1, 2022**]** March 1, 2025, and annually thereafter, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. The report shall contain (1) an aggregation of the information submitted to the commissioner pursuant to subsection (a) of this section for the immediately preceding calendar year, and (2) such other information as the commissioner, in the commissioner's discretion, deems relevant for the purposes of this section. Not later than **[**February 1, 2022, and annually thereafter**]** ten days prior to the submission of the annual report pursuant to the provisions of this subsection, the commissioner shall provide each pharmacy benefits manager and any third party affected by submission of **[**a**]** such report required by this subsection

with a written notice describing the content of the report.

(e) The commissioner may impose a penalty of not more than seven thousand five hundred dollars on a pharmacy benefits manager for each violation of this section.

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

Sec. 11. Subdivision (4) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(4) (A) "Small employer" means (i) prior to January 1, 2016, an employer that employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year, **[**and**]** (ii) on and after January 1, 2016, and prior to January 1, 2025, an employer that employed an average of at least one but not more than one hundred employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year, except the commissioner may postpone said January 1, 2016, date to be consistent with any such postponement made by the Secretary of the United States Department of Health and Human Services under the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and (iii) on and after January 1, 2025, an employer that employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance plan year. "Small employer" does not include a sole proprietorship that employs only the sole proprietor or the spouse of such sole proprietor.

(B) (i) For purposes of subparagraph (A) of this subdivision, the number of employees shall be determined by adding (I) the number of full-time employees for each month who work a normal work week of thirty hours or more, and (II) the number of full-time equivalent

employees, calculated for each month by dividing by one hundred twenty the aggregate number of hours worked for such month by employees who work a normal work week of less than thirty hours, and averaging such total for the calendar year.

(ii) If an employer was not in existence throughout the preceding calendar year, the number of employees shall be based on the average number of employees that such employer reasonably expects to employ in the current calendar year.

(C) All persons treated as a single employer under Section 414 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, shall be considered a single employer for purposes of this subdivision.

Sec. 12. Subdivision (1) of section 38a-614 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(1) Each domestic society transacting business in this state shall, annually, on or before the first day of March, unless the commissioner has extended such time for cause shown, file with the commissioner, and electronically to the National Association of Insurance Commissioners, a true and complete statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee specified in section 38a-11 for filing such annual statement. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner. An electronically filed true and complete report filed in accordance with section 38a-53a that is timely submitted to the National Association of Insurance Commissioners shall **[**not exempt a domestic society from timely filing a true and complete paper copy with the commissioner**]** be deemed to have been submitted to the commissioner in accordance with the provisions of this section.

Sec. 13. Subsection (b) of section 38a-591*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(b) (1) Any independent review organization seeking to conduct external reviews and expedited external reviews under section 38a-591g shall submit the application form for approval or reapproval, as applicable, to the commissioner and shall include all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under this section.

(2) An approval or reapproval shall be effective for **[**two**]** three years, unless the commissioner determines before the expiration of such approval or reapproval that the independent review organization no longer satisfies the minimum qualifications established under this section.

(3) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under this section, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of approved independent review organizations specified in subdivision (2) of subsection (a) of this section.

Sec. 14. Section 38a-91aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

As used in this section, sections 38a-91bb to 38a-91uu, inclusive, **[**and**]** sections 38a-91ww, **[**and**]** 38a-91xx and section 15 of this act:

(1) "Affiliated company" means any company in the same corporate system as a parent, an industrial insured or a member organization by virtue of common ownership, control, operation or management.

(2) "Agency captive insurance company" means a captive insurance

company that:

(A) Is owned or directly or indirectly controlled by one or more insurance agents or insurance producers licensed in accordance with sections 38a-702a to 38a-702r, inclusive;

(B) Only insures against risks covered by insurance policies sold, solicited or negotiated through the insurance agents or insurance producers that own or control such captive insurance company; and

(C) Does not insure against risks covered by any health insurance policy or plan.

(3) "Alien captive insurance company" means any insurance company formed to write insurance business for its parent and affiliated companies and licensed pursuant to the laws of an alien jurisdiction that imposes statutory or regulatory standards on companies transacting the business of insurance in such jurisdiction that the commissioner deems to be acceptable.

(4) "Association" means any legal association of individuals, corporations, limited liability companies, partnerships, associations or other entities, where the association itself or some or all of the member organizations:

(A) Directly or indirectly own, control or hold with power to vote all of the outstanding voting securities or other voting interests of an association captive insurance company incorporated as a stock insurer;

(B) Have complete voting control over an association captive insurance company incorporated as a mutual corporation or formed as a limited liability company; or

(C) Constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer.

(5) "Association captive insurance company" means any company that insures risks of the member organizations of an association, and

includes a company that also insures risks of such member organizations' affiliated companies or of the association.

(6) "Branch business" means any insurance business transacted in this state by a branch captive insurance company.

(7) "Branch captive insurance company" means any alien captive insurance company or foreign captive insurance company licensed by the commissioner to transact the business of insurance in this state through a business unit with a principal place of business in this state.

(8) "Branch operations" means any business operations in this state of a branch captive insurance company.

(9) "Captive insurance company" means any (A) pure captive insurance company, agency captive insurance company, association captive insurance company, industrial insured captive insurance company, risk retention group, sponsored captive insurance company or special purpose financial captive insurance company that is domiciled in this state and formed or licensed under the provisions of this section and sections 38a-91bb to 38a-91tt, inclusive, or (B) branch captive insurance company.

(10) "Ceding insurer" means an insurance company, approved by the commissioner and licensed or otherwise authorized to transact the business of insurance or reinsurance in its state or country of domicile, that cedes risk to a special purpose financial captive insurance company pursuant to a reinsurance contract.

(11) "Commissioner" means the Insurance Commissioner.

(12) "Controlled unaffiliated business" means any person:

(A) Who, (i) in the case of a pure captive insurance company, is not in the corporate system of a parent and the parent's affiliated companies, (ii) in the case of an industrial insured captive insurance company, is not in the corporate system of an industrial insured and the industrial insured's affiliated companies, or (iii) in the case of a sponsored captive

insurance company, is not in the corporate system of a participant and the participant's affiliated companies;

(B) Who, (i) in the case of a pure captive insurance company, has an existing contractual relationship with a parent or one of the parent's affiliated companies, (ii) in the case of an industrial insured captive insurance company, has an existing contractual relationship with an industrial insured or one of the industrial insured's affiliated companies, or (iii) in the case of a sponsored captive insurance company, has an existing contractual relationship with a participant or one of the participant's affiliated companies; and

(C) Whose risks are managed by a pure captive insurance company, an industrial insured captive insurance company or a sponsored captive insurance company, as applicable, in accordance with section 38a-91qq.

(13) "Excess workers' compensation insurance" means, in the case of an employer that has insured or self-insured its workers' compensation risks in accordance with applicable state or federal law, insurance in excess of a specified per-incident or aggregate limit established by the commissioner.

(14) "Foreign captive insurance company" means any insurance company formed to write insurance business for its parent and affiliated companies and licensed pursuant to the laws of a foreign jurisdiction that imposes statutory or regulatory standards on companies transacting the business of insurance in such jurisdiction that the commissioner deems to be acceptable.

(15) "Incorporated protected cell" means a protected cell that is established as a corporation or a limited liability company, separate from the sponsored captive insurance company with which it has entered into a participant contract.

(16) "Industrial insured" means an insured:

(A) Who procures the insurance of any risk or risks by use of the

services of a full-time employee acting as an insurance manager or buyer;

(B) Whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars; and

(C) Who has at least twenty-five full-time employees.

(17) "Industrial insured captive insurance company" means any company that insures risks of the industrial insureds that comprise an industrial insured group, and includes a company that also insures risks of such industrial insureds' affiliated companies.

(18) "Industrial insured group" means any group of industrial insureds that collectively:

(A) Directly or indirectly own, control or hold with power to vote all of the outstanding voting securities or other voting interests of an industrial insured captive insurance company incorporated as a stock insurer;

(B) Have complete voting control over an industrial insured captive insurance company incorporated as a mutual corporation or formed as a limited liability company; or

(C) Constitute all of the subscribers of an industrial insured captive insurance company formed as a reciprocal insurer.

(19) "Insurance securitization" or "securitization" means a transaction or a group of related transactions, which may include capital market offerings, that are effected through related risk transfer instruments and facilitating administrative agreements, in which all or part of the result of such transaction is used to fund a special purpose financial captive insurance company's obligations under a reinsurance contract with a ceding insurer and by which:

(A) A special purpose financial captive insurance company directly or indirectly obtains proceeds through the issuance of securities by such

company or any other person; or

(B) A person provides, for the benefit of a special purpose financial captive insurance company, one or more letters of credit or other assets that the commissioner has authorized such company to treat as admitted assets for purposes of its annual report. "Insurance securitization" or "securitization" does not include the issuance of a letter of credit for the benefit of the commissioner to satisfy all or part of a special purpose financial captive insurance company's capital and surplus requirements under section 38a-91dd.

(20) "Member organization" means any individual, corporation, limited liability company, partnership, association or other entity that belongs to an association.

(21) "Mutual corporation" means a corporation organized without stockholders and includes a nonprofit corporation with members.

(22) "Parent" means any individual, corporation, limited liability company, partnership or other entity that directly or indirectly owns, controls or holds with power to vote more than fifty per cent of the outstanding voting:

(A) Securities of a pure captive insurance company organized as a stock insurer; or

(B) Membership interests of a pure captive insurance company organized as a nonprofit corporation or as a limited liability company.

(23) "Participant" means any association, corporation, limited liability company, partnership, trust or other entity, and any affiliated company or controlled unaffiliated business thereof, that is insured by a sponsored captive insurance company pursuant to a participant contract.

(24) "Participant contract" means a contract entered into by a sponsored captive insurance company and a participant by which the sponsored captive insurance company insures the risks of the

participant and limits the losses of each such participant to its pro rata share of the assets of one or more protected cells identified in such participant contract.

(25) "Protected cell" means a separate account established by a sponsored captive insurance company, in which assets are maintained for one or more participants in accordance with the terms of one or more participant contracts to fund the liability of the sponsored captive insurance company assumed on behalf of such participants as set forth in such participant contracts.

(26) "Pure captive insurance company" means any company that insures risks of its parent and affiliated companies or controlled unaffiliated business.

(27) "Reinsurance contract" means a contract entered into by a special purpose financial captive insurance company and a ceding insurer by which the special purpose financial captive insurance company agrees to provide reinsurance to the ceding insurer for risks associated with the ceding insurer's insurance or reinsurance business.

(28) "Risk retention group" means a captive insurance company organized under the laws of this state pursuant to the federal Liability Risk Retention Act of 1986, 15 USC 3901 et seq., as amended from time to time, as a stock insurer or mutual corporation, a reciprocal or other limited liability entity.

(29) "Security" has the same meaning as provided in section 36b-3 and includes any form of debt obligation, equity, surplus certificate, surplus note, funding agreement, derivative or other financial instrument that the commissioner designates as a security for purposes of this section and sections 38a-91bb to 38a-91tt, inclusive.

(30) "Special purpose financial captive insurance company" means a company that is licensed by the commissioner in accordance with section 38a-91bb.

(31) "Special purpose financial captive insurance company security" means a security issued by (A) a special purpose financial captive insurance company, or (B) a third party, the proceeds of which are obtained directly or indirectly by a special purpose financial captive insurance company.

(32) "Sponsor" means any association, corporation, limited liability company, partnership, trust or other entity that is approved by the commissioner to organize and operate a sponsored captive insurance company and to provide all or part of the required unimpaired paid-in capital and surplus.

(33) "Sponsored captive insurance company" means a captive insurance company:

(A) In which the minimum required unimpaired paid-in capital and surplus are provided by one or more sponsors;

(B) That insures risks of its participants only through separate participant contracts; and

(C) That funds its liability to each participant through one or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the sponsored captive insurance company's general account.

(34) "Surplus note" means an unsecured subordinated debt obligation possessing characteristics consistent with the National Association of Insurance Commissioners Statement of Statutory Accounting Principles No. 41, as amended from time to time, and as modified or supplemented by the commissioner.

Sec. 15. (NEW) (*Effective October 1, 2024*) (a) (1) Any sponsored captive insurance company, including a sponsored captive insurance company licensed as a special purpose financial captive insurance company, may, upon application of such sponsored captive insurance company and with the commissioner's prior written approval, convert one or more

protected cells or incorporated protected cells into a:

(A) Single protected cell or incorporated protected cell;

(B) New sponsored captive insurance company;

(C) New sponsored captive insurance company licensed as a special purpose financial captive insurance company;

(D) New special purpose financial captive insurance company;

(E) New pure captive insurance company;

(F) New risk retention group;

(G) New agency captive insurance company;

(H) New industrial insured captive insurance company; or

(I) New association captive insurance company.

(2) Any such conversion of a protected cell or incorporated protected cell, in accordance with subdivision (1) of this subsection, shall be subject to the provisions of sections 38a-91aa to 38a-91xx, inclusive, of the general statutes, as amended by this act, as applicable, and such sponsored captive insurance company's plan of operation approved by the commissioner, without affecting such converted protected cell's or incorporated protected cell's assets, rights, benefits, obligations and liabilities.

(b) Any conversion of a protected cell or incorporated protected cell shall be deemed to be a continuation of such protected cell's or incorporated protected cell's existence together with all of such protected cell's or incorporated protected cell's assets, rights, benefits, obligations and liabilities, as (1) a new protected cell or incorporated protected cell, (2) a sponsored captive insurance company, (3) a sponsored captive insurance company licensed as a special purpose financial captive insurance company, (4) a pure captive insurance company, (5) a risk retention group, (6) an industrial insured captive

insurance company, or (7) an association captive insurance company, as applicable. Any such conversion of a protected cell or incorporated protected cell shall be deemed to occur without any transfer or assignment of such cell's assets, rights, benefits, obligations or liabilities, and without the creation of any reversionary interest in, or impairment of, any such assets, rights, benefits, obligations or liabilities.

(c) Any conversion of a protected cell or incorporated protected cell shall not be construed to limit any rights or protections applicable to such converted protected cell or incorporated protected cell or applicable to such sponsored captive insurance company or sponsored captive insurance company licensed as a special purpose financial captive insurance company, as applicable, that existed immediately prior to the date of such conversion.

(d) Any protected cell or incorporated protected cell that converts into an incorporated protected cell, a new captive insurance company or risk retention group, in accordance with the provisions of this section, shall perform such conversion in accordance with chapter 601 or 613 of the general statutes, as applicable, or in accordance with any such provisions of the general statutes applicable to the formation of any other type of legal entity permissible under the laws of this state, as applicable.

Sec. 16. Subsection (c) of section 38a-511 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(c) The provisions of subsections (a) and (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-493 or a copayment-only health plan that is delivered, issued for delivery, renewed, amended or continued on or after January 1, 2025. For purposes of this section, "copayment-only health plan" means a health insurance policy that (1) imposes a specific dollar amount to be paid by the insured for a health care service paid for or reimbursed by such health insurance policy, and (2) imposes no

deductibles, coinsurance or other out-of-pocket expense, except as provided in subdivision (1) of this subsection, for any such service.

Sec. 17. Section 38a-511a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall impose copayments that exceed a maximum of thirty dollars per visit for in-network (1) physical therapy services rendered by a physical therapist licensed under section 20-73, or (2) occupational therapy services rendered by an occupational therapist licensed under section 20-74b or 20-74c. The provisions of this section shall not apply to a copayment-only health plan that is delivered, issued for delivery, renewed, amended or continued on or after January 1, 2025. For purposes of this section, "copayment-only health plan" means a health insurance policy that (1) imposes a specific dollar amount to be paid by the insured for a health care service paid for or reimbursed by such health insurance policy, and (2) imposes no deductibles, coinsurance or other out-of-pocket expense.

Sec. 18. Subsection (c) of section 38a-550 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(c) The provisions of subsections (a) and (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520 or a copayment-only health plan that is delivered, issued for delivery, renewed, amended or continued on or after January 1, 2025. For purposes of this section, "copayment-only health plan" means a health insurance policy that (1) imposes a specific dollar amount to be paid by the insured for a health care service paid for or reimbursed by such health insurance policy, and (2) imposes no deductibles, coinsurance or other out-of-pocket expense, except as provided in subdivision (1) of this subsection, for any such service.

Sec. 19. Section 38a-550a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall impose copayments that exceed a maximum of thirty dollars per visit for in-network (1) physical therapy services rendered by a physical therapist licensed under section 20-73, or (2) occupational therapy services rendered by an occupational therapist licensed under section 20-74b or 20-74c. The provisions of this section shall not apply to a copayment-only health plan that is delivered, issued for delivery, renewed, amended or continued on or after January 1, 2025. For purposes of this section, "copayment-only health plan" means a health insurance policy that (1) imposes a specific dollar amount to be paid by the insured for a health care service paid for or reimbursed by such health insurance policy, and (2) imposes no deductibles, coinsurance or other out-of-pocket expense.

Sec. 20. Section 19a-754c of the general statutes is amended by adding subsection (f) as follows (*Effective October 1, 2024*):

(NEW) (f) Notwithstanding any provision of this section, the Covered Connecticut program shall only include in-network health care providers and in-network services, unless the health carrier's network is deemed by the Insurance Commissioner to be inadequate. Benefits described in subsection (b) of this section and cost-sharing available to all eligible individuals pursuant to subdivision (1) of subsection (b) of this section shall only apply if such eligible individuals use in-network health care providers or in-network facilities.

Sec. 21. Section 38a-556 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is hereby created a nonprofit legal entity to be known as the Health Reinsurance Association. All insurers, health care centers and self-insurers doing business in the state, as a condition to their authority

to transact the applicable kinds of health insurance defined in section 38a-551, shall be members of the association. The association shall perform its functions under a plan of operation established and approved under subsection (b) of this section, and shall exercise its powers through a board of directors established under this section.

(b) (1) The board of directors of the association shall be made up of nine individuals selected by participating members, subject to approval by the commissioner, two of whom shall be appointed by the commissioner on or before July 1, 1993, to represent health care centers. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the net health insurance premium derived from this state in the previous calendar year. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner. Such plan shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall: (A) Establish procedures for the handling and accounting of assets and moneys of the association; (B) establish regular times and places for meetings of the board of directors; (C) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner; (D)

establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner; (E) establish procedures to amend, subject to the approval of the commissioner, the plan of operations; (F) establish procedures for the selection of an administrator and set forth the powers and duties of the administrator; (G) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and (H) contain additional provisions necessary for the association to establish health insurance plans that qualify as acceptable coverage in accordance with the Pension Benefit Guaranty Corporation and other state or federal programs that may be established.

(c) The association shall have the general powers and authority granted under the laws of this state to carriers to transact the kinds of insurance defined under section 38a-551, and in addition thereto, the specific authority to: (1) Enter into contracts necessary or proper to carry out the provisions and purposes of this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive; (2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members; (3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association; (4) establish, with respect to health insurance provided by or on behalf of the association, appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the operational expenses of the association; (5) administer any type of reinsurance program, for or on behalf of participating members; (6) pool risks among participating members; (7) issue policies of insurance required or permitted by this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive, in its own name or on behalf of participating members; (8) administer separate pools, separate accounts or other plans as deemed appropriate for separate members or groups of members; (9) operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best

accomplish the fair and equitable operation of the association; (10) set limits on the amounts of reinsurance that may be ceded to the association by its members; (11) appoint from among participating members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association; (12) apply for and accept grants, gifts and bequests of funds from other states, federal and interstate agencies and independent authorities, private firms, individuals and foundations for the purpose of carrying out its responsibilities. Any such funds received shall be deposited in the General Fund and shall be credited to a separate nonlapsing account within the General Fund for the Health Reinsurance Association and may be used by the Health Reinsurance Association in the performance of its duties; and (13) perform such other duties and responsibilities as may be required by state or federal law or permitted by state or federal law and approved by the commissioner.

(d) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed with the commissioner and may be disapproved within sixty days after the filing thereof if excessive, inadequate or unfairly discriminatory.

(e) (1) Following the close of each fiscal year, the administrator shall determine the net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all participating members in proportion to their respective shares of the total health insurance premiums earned in this state during the calendar year, or with paid losses in the year, coinciding with or ending during the fiscal year of the association or on any other equitable basis as may be provided in the plan of operations. For self-insured members of the association, health insurance premiums earned shall be established by dividing the amount

of paid health losses for the applicable period by eighty-five per cent. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(2) Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to those participating members who do not elect to administer their plans. All assessments shall be on an equitable formula established by the board.

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association and the association shall have an annual audit of its operations by an independent certified public accountant. The annual audit shall be filed with the commissioner for his review and the association shall be subject to the provisions of section 38a-14.

(f) All policy forms issued by or through the association shall conform in substance to prototype forms developed by the association, shall in all other respects conform to the requirements of this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy.

(g) Unless otherwise permitted by the plan of operation, the association shall not issue, reissue or continue in force health care plan coverage with respect to any person who is already covered under an individual or group health care plan, or who is sixty-five years of age or older and eligible for Medicare or who is not a resident of this state.

(h) Benefits payable under a health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medicaid.

(i) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the Health Reinsurance Association or its agents or its employees or the residual market mechanism established under the provisions of section 38a-557 or its agents or its employees, or the commissioner or the commissioner's representatives for any action taken by them in the performance of their duties under this section and sections 38a-551 and **[**38a-556a**]** 38a-557 to 38a-559, inclusive. This provision shall not apply to the obligations of a carrier, a self-insurer, the Health Reinsurance Association or the residual market mechanism for payment of benefits provided under a health care plan.

Sec. 22. Section 38a-556a of the general statutes is repealed. (*Effective from passage*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2024*	38a-8(a)
Sec. 2	*October 1, 2024*	38a-702k
Sec. 3	*October 1, 2024*	38a-16
Sec. 4	*October 1, 2024*	38a-790(a)
Sec. 5	*October 1, 2024*	38a-792(a)
Sec. 6	*October 1, 2024*	38a-48
Sec. 7	*October 1, 2024*	38a-53(a)
Sec. 8	*October 1, 2024*	38a-54(a)
Sec. 9	*October 1, 2024*	38a-297
Sec. 10	*January 1, 2025*	38a-479ppp
Sec. 11	*October 1, 2024*	38a-564(4)
Sec. 12	*October 1, 2024*	38a-614(1)
Sec. 13	*October 1, 2024*	38a-591l(b)
Sec. 14	*October 1, 2024*	38a-91aa
Sec. 15	*October 1, 2024*	New section
Sec. 16	*July 1, 2024*	38a-511(c)
Sec. 17	*July 1, 2024*	38a-511a
Sec. 18	*July 1, 2024*	38a-550(c)
Sec. 19	*July 1, 2024*	38a-550a
Sec. 20	*October 1, 2024*	19a-754c(f)
Sec. 21	*from passage*	38a-556

Sec. 22	*from passage*	Repealer section