General Assembly

Raised Bill No. 400

February Session, 2024

LCO No. **2706**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING THE INSURANCE DEPARTMENT'S TECHNICAL CORRECTIONS AND OTHER REVISIONS TO THE INSURANCE STATUTES.

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

Section 1. Section 38a-48 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):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 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, 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 has converted to a domestic mutual insurance company pursuant to section 38a-155 upon the effective date of any public act which 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. 2. 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. 3. 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. 4. 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. 5. 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. 6. 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. 7. 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. 8. 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. 9. 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. 10. 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-48
Sec. 2	*October 1, 2024*	38a-53(a)
Sec. 3	*October 1, 2024*	38a-54(a)
Sec. 4	*October 1, 2024*	38a-297
Sec. 5	*January 1, 2025*	38a-479ppp
Sec. 6	*from passage*	38a-556
Sec. 7	*October 1, 2024*	38a-564(4)
Sec. 8	*October 1, 2024*	38a-614(1)
Sec. 9	*October 1, 2024*	38a-591l(b)
Sec. 10	*from passage*	Repealer section

Statement of Purpose:

To: (1) Require the Insurance Commissioner to manage the administration of the Insurance Fund on behalf of agencies that are supported by the Insurance Fund; (2) remove certain paper filing requirements for insurance companies and to permit the filing of certain reports with the National Association of Insurance Commissioners; (3) establish filing requirements for non-English policy forms; (4) repeal an existing law requiring the maintenance of an Internet web site for a health reinsurance pool; and (5) extend the approval or reapproval period for independent review organizations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]