



# House of Representatives

General Assembly

**File No. 241**

February Session, 2026

Substitute House Bill No. 5373

*House of Representatives, March 30, 2026*

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

***AN ACT CONCERNING THE INSURANCE DEPARTMENT'S  
RECOMMENDATIONS FOR REVISIONS TO THE INSURANCE  
STATUTES.***

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

1 Section 1. Section 38a-26 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective October 1, 2026*):

3 (a) Service of process on the commissioner as provided in section 38a-  
4 25 shall be made by delivering two copies thereof to the commissioner,  
5 or to the office of the commissioner, or to an official or office of an official  
6 designated by the commissioner to receive service. The person serving  
7 process shall pay to the office of the commissioner the fee set for that  
8 service by section 38a-11, for each person or insurer to be served.

9 (b) The commissioner shall immediately send by registered, [or]  
10 certified or electronic mail one copy of the process to the person to be  
11 served as follows: (1) To that person's last-known principal place of  
12 business, residence, [or] post-office address or electronic mail address,

13 or (2) if a foreign insurance company, to the secretary of the company or  
14 designee of the company, or (3) if an alien insurance company, to the  
15 resident manager, if any, in this country, or (4) if a fraternal benefit  
16 society, to the secretary or corresponding officer of the society. Service  
17 by electronic mail as provided in this subsection shall be made to the  
18 last-known electronic mail address of the person, secretary, designee,  
19 resident manager, secretary or officer to be notified, as applicable, as  
20 filed with and maintained by the commissioner.

21 (c) The commissioner shall retain the second copy of the process for  
22 his files. The commissioner shall keep a record of all process served,  
23 showing the day and hour of service.

24 (d) Proof of service shall be evidenced by a certificate signed by the  
25 commissioner or by the official designated to receive service of process,  
26 showing the service made on him and mailing by him, attached to the  
27 second copy of the process.

28 (e) No plaintiff or complainant shall be entitled to a judgment or  
29 determination by default in any action or proceeding in which the  
30 process is served under this section until the expiration of forty-five  
31 days from the date of service of process commencing the action or  
32 proceeding.

33 Sec. 2. Section 38a-774 of the general statutes is repealed and the  
34 following is substituted in lieu thereof (*Effective October 1, 2026*):

35 (a) The commissioner, after reasonable notice to and hearing of any  
36 licensee, may suspend or revoke the licensee's license for cause shown.  
37 In addition to or in lieu of suspension or revocation, the commissioner  
38 may impose a fine not to exceed five thousand dollars. Hearings may be  
39 held by the commissioner or by any person designated by the  
40 commissioner. Whenever a person other than the commissioner acts as  
41 the hearing officer, such person shall submit to the commissioner a  
42 memorandum of the findings and recommendations upon which the  
43 commissioner may base a decision.

44 (b) Notwithstanding the provisions of subsection (c) of section 4-182,  
45 the commissioner may provide notice of suspension or revocation of a  
46 license pursuant to this section or section 4-182 to any person licensed  
47 by or registered with the commissioner by personal delivery, as defined  
48 in section 4-166. For any firm, association or corporation licensed by or  
49 registered with the commissioner, the electronic mail address of any  
50 natural persons designated as a primary contact by such firm,  
51 association or corporation shall constitute an acceptable means of  
52 communication for personal delivery, and a notice sent by electronic  
53 mail to such primary contact at the primary contact's electronic mail  
54 address shall constitute notice of suspension or revocation of such  
55 license. For any natural person licensed by or registered with the  
56 commissioner, the electronic mail address for such licensed or registered  
57 person shall constitute an acceptable means of communication for  
58 personal delivery, and a notice sent by electronic mail to such natural  
59 person's electronic mail address shall constitute notice of suspension or  
60 revocation of such license. Any notice provided in accordance with the  
61 provisions of this section shall be deemed received by such primary  
62 contact or natural person on the earlier of the date of actual receipt by  
63 such primary contact or natural person to whom such notice was sent  
64 or seven days after the date such notice is postmarked or sent by  
65 electronic mail.

66 [(b)] (c) If an insurance license held by a firm, association or  
67 corporation is revoked, the insurance licenses of any principal of such  
68 firm or association or any officer or director of such corporation shall be  
69 revoked, unless the commissioner determines that such principal,  
70 officer or director was not personally at fault in the matter on account of  
71 which such license held by the firm, association or corporation was  
72 revoked.

73 [(c)] (d) Any person aggrieved by the action of the commissioner in  
74 revoking, suspending or refusing to grant or reissue a license or in  
75 imposing a fine may appeal therefrom in accordance with the provisions  
76 of section 4-183, except venue for such appeal shall be in the judicial  
77 district of New Britain. Appeals under this section shall be privileged in

78 respect to the order of trial assignment.

79 Sec. 3. Section 51-344b of the 2026 supplement to the general statutes  
80 is repealed and the following is substituted in lieu thereof (*Effective*  
81 *October 1, 2026*):

82 Whenever the term "judicial district of Hartford" is used or referred  
83 to in the following sections of the general statutes, the term "judicial  
84 district of New Britain" shall be substituted in lieu thereof: Subsection  
85 (b) of section 3-70a, sections 3-71a and 4-164, subsection (c) of section 4-  
86 183, subdivision (4) of subsection (g) of section 10-153e, subparagraph  
87 (C) of subdivision (4) of subsection (e) of section 10a-109n, sections 12-  
88 3a, 12-89, 12-103, 12-208, 12-237, 12-242hh, 12-242ii, 12-242kk, 12-268l,  
89 12-307, 12-312, 12-330m, 12-405k, 12-422, 12-448, 12-454, 12-463, 12-489,  
90 12-522, 12-554, 12-586g and 12-597, subsection (b) of section 12-638i,  
91 sections 12-730, 14-57, 14-66, 14-195, 14-324, 14-331 and 19a-85,  
92 subsection (f) of section 19a-332e, sections 20-156, 20-247, 20-307, 20-373,  
93 20-583 and 21a-55, subsection (e) of section 22-7, sections 22-320d and  
94 22-386, subsection (e) of section 22a-6b, section 22a-30, subsection (a) of  
95 section 22a-34, subsection (b) of section 22a-34, section 22a-182a,  
96 subsection (f) of section 22a-225, sections 22a-227, 22a-344, 22a-374 and  
97 22a-408, subsection (f) of section 25-32e, section 29-158, subsection (f) of  
98 section 29-161z, sections 36b-30 and 36b-76, subsection (f) of section 38a-  
99 41, section 38a-52, subsection (c) of section 38a-150, sections 38a-185,  
100 38a-209 and 38a-225, subdivision (3) of section 38a-226b, sections 38a-  
101 241, 38a-337 and 38a-657, subsection [(c)] (d) of section 38a-774, as  
102 amended by this act, section 38a-776, subsection (c) of section 38a-817  
103 and section 38a-994.

104 Sec. 4. Subdivision (5) of subsection (b) of section 19a-7j of the general  
105 statutes is repealed and the following is substituted in lieu thereof  
106 (*Effective October 1, 2026*):

107 (5) (A) Not later than December first, annually, the Insurance  
108 Commissioner shall submit a statement to each such insurer, health care  
109 center, third-party administrator and exempt insurer that includes the  
110 proposed fee, identified on such statement as the "Health and Welfare

111 fee", for the insurer, health care center, third-party administrator or  
112 exempt insurer calculated in accordance with this subsection. Not later  
113 than December twentieth, annually, any insurer, health care center,  
114 third-party administrator or exempt insurer may submit an objection to  
115 the commissioner concerning the proposed fee. The commissioner, after  
116 making any adjustment that the commissioner deems necessary, shall,  
117 not later than January first, annually, submit a final statement to each  
118 insurer, health care center, third-party administrator and exempt  
119 insurer that includes the final fee for the insurer, health care center,  
120 third-party administrator or exempt insurer. Each such insurer, health  
121 care center, third-party administrator and exempt insurer shall pay such  
122 fee to the Insurance Commissioner not later than February first,  
123 annually.

124 (B) Any such insurer, health care center, third-party administrator or  
125 exempt insurer aggrieved by an assessment levied under this subsection  
126 may appeal therefrom in the same manner as provided for appeals  
127 under section 38a-52.

128 Sec. 5. Section 38a-48 of the general statutes is repealed and the  
129 following is substituted in lieu thereof (*Effective October 1, 2026*):

130 (a) On or before ~~June thirtieth~~ August thirty-first, annually, the  
131 Commissioner of Revenue Services shall render to the Insurance  
132 Commissioner a statement certifying the total amount of taxes reported  
133 to the Commissioner of Revenue Services on returns filed with said  
134 commissioner by each domestic insurance company or other domestic  
135 entity under chapter 207 on business done in this state during the  
136 calendar year immediately preceding the prior calendar year. For  
137 purposes of preparing the annual statement under this subsection, the  
138 total amount of taxes required to be set forth in such statement shall be  
139 the amount of tax reported by each domestic insurance company or  
140 other domestic entity under chapter 207 to the Commissioner of  
141 Revenue Services prior to the application of any credits allowable or  
142 available under law to each such domestic insurance company or other  
143 domestic entity under chapter 207.

144 (b) On or before ~~July thirty-first~~ September fifteenth, annually, the  
145 Insurance Commissioner shall render to each domestic insurance  
146 company or other domestic entity liable for payment under section 38a-  
147 47:

148 (1) A statement that includes (A) the amount appropriated to the  
149 Insurance Department, the Office of the Healthcare Advocate, the Office  
150 of the Behavioral Health Advocate and the Office of Health Strategy  
151 from the Insurance Fund established under section 38a-52a for the fiscal  
152 year beginning July first of the same year, (B) the cost of fringe benefits  
153 for department and office personnel for such year, as estimated by the  
154 Comptroller, (C) the estimated expenditures on behalf of the  
155 department and the offices from the Capital Equipment Purchase Fund  
156 pursuant to section 4a-9 for such year, not including such estimated  
157 expenditures made on behalf of the Health Systems Planning Unit of the  
158 Office of Health Strategy, and (D) the amount appropriated to the  
159 Department of Aging and Disability Services for the fall prevention  
160 program established in section 17a-859 from the Insurance Fund for the  
161 fiscal year;

162 (2) A statement of the total amount of taxes reported in the annual  
163 statement rendered to the Insurance Commissioner pursuant to  
164 subsection (a) of this section; and

165 (3) The proposed assessment against that company or entity,  
166 calculated in accordance with the provisions of subsection (c) of this  
167 section, provided for the purposes of this calculation the amount  
168 appropriated to the Insurance Department, the Office of the Healthcare  
169 Advocate, the Office of the Behavioral Health Advocate and the Office  
170 of Health Strategy from the Insurance Fund plus the cost of fringe  
171 benefits for department and office personnel and the estimated  
172 expenditures on behalf of the department and said offices from the  
173 Capital Equipment Purchase Fund pursuant to section 4a-9, not  
174 including such expenditures made on behalf of the Health Systems  
175 Planning Unit of the Office of Health Strategy shall be deemed to be the  
176 actual expenditures of the department and said offices, and the amount

177 appropriated to the Department of Aging and Disability Services from  
178 the Insurance Fund for the fiscal year for the fall prevention program  
179 established in section 17a-859 shall be deemed to be the actual  
180 expenditures for the program.

181 (c) (1) The proposed assessments for each domestic insurance  
182 company or other domestic entity shall be calculated by (A) allocating  
183 twenty per cent of the amount to be paid under section 38a-47 among  
184 the domestic entities organized under sections 38a-199 to 38a-209,  
185 inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their  
186 respective shares of the total amount of taxes reported in the annual  
187 statement rendered to the Insurance Commissioner pursuant to  
188 subsection (a) of this section, and (B) allocating eighty per cent of the  
189 amount to be paid under section 38a-47 among all domestic insurance  
190 companies and domestic entities other than those organized under  
191 sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive,  
192 in proportion to their respective shares of the total amount of taxes  
193 reported in the annual statement rendered to the Insurance  
194 Commissioner pursuant to subsection (a) of this section, provided if  
195 there are no domestic entities organized under sections 38a-199 to 38a-  
196 209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of  
197 assessment, one hundred per cent of the amount to be paid under  
198 section 38a-47 shall be allocated among such domestic insurance  
199 companies and domestic entities.

200 (2) When the amount any such company or entity is assessed  
201 pursuant to this section exceeds twenty-five per cent of the actual  
202 expenditures of the Insurance Department, the Office of the Healthcare  
203 Advocate, the Office of the Behavioral Health Advocate and the Office  
204 of Health Strategy from the Insurance Fund, such excess amount shall  
205 not be paid by such company or entity but rather shall be assessed  
206 against and paid by all other such companies and entities in proportion  
207 to their respective shares of the total amount of taxes reported in the  
208 annual statement rendered to the Insurance Commissioner pursuant to  
209 subsection (a) of this section, except that for purposes of any assessment  
210 made to fund payments to the Department of Public Health to purchase

211 vaccines, such company or entity shall be responsible for its share of the  
212 costs, notwithstanding whether its assessment exceeds twenty-five per  
213 cent of the actual expenditures of the Insurance Department, the Office  
214 of the Healthcare Advocate, the Office of the Behavioral Health  
215 Advocate and the Office of Health Strategy from the Insurance Fund.  
216 The provisions of this subdivision shall not be applicable to any  
217 corporation that has converted to a domestic mutual insurance  
218 company pursuant to section 38a-155 upon the effective date of any  
219 public act that amends said section to modify or remove any restriction  
220 on the business such a company may engage in, for purposes of any  
221 assessment due from such company on and after such effective date.

222 (d) Each annual payment determined under section 38a-47 and each  
223 annual assessment determined under this section shall be calculated  
224 based on the total amount of taxes reported in the annual statement  
225 rendered to the Insurance Commissioner pursuant to subsection (a) of  
226 this section.

227 (e) On or before [~~September~~] October first, annually, for each fiscal  
228 year, the Insurance Commissioner, after receiving any objections to the  
229 proposed assessments and making such adjustments as in the  
230 commissioner's opinion may be indicated, shall assess each such  
231 domestic insurance company or other domestic entity an amount equal  
232 to its proposed assessment as so adjusted. Each domestic insurance  
233 company or other domestic entity shall pay to the Insurance  
234 Commissioner (1) on or before June thirtieth, annually, an estimated  
235 payment against its assessment for the following year equal to [~~twenty-~~  
236 ~~five~~] thirty-five per cent of its assessment for the fiscal year ending such  
237 June thirtieth, (2) on or before [~~September thirtieth~~] October thirty-first,  
238 annually, twenty-five per cent of its assessment adjusted to reflect any  
239 credit or amount due from the preceding fiscal year as determined by  
240 the commissioner under subsection (f) of this section, and (3) on or  
241 before the following December thirty-first and March thirty-first,  
242 annually, each domestic insurance company or other domestic entity  
243 shall pay to the Insurance Commissioner the remaining [~~fifty~~] forty per  
244 cent of its proposed assessment to the department in two equal

245 installments.

246 (f) If the actual expenditures for the fall prevention program  
247 established in section 17a-859 are less than the amount allocated, the  
248 Commissioner of Aging and Disability Services shall notify the  
249 Insurance Commissioner. Immediately following the close of the fiscal  
250 year, the Insurance Commissioner shall recalculate the proposed  
251 assessment for each domestic insurance company or other domestic  
252 entity in accordance with subsection (c) of this section using the actual  
253 expenditures made during the fiscal year by the Insurance Department,  
254 the Office of the Healthcare Advocate, the Office of the Behavioral  
255 Health Advocate and the Office of Health Strategy from the Insurance  
256 Fund, the actual expenditures made on behalf of the department and  
257 said offices from the Capital Equipment Purchase Fund pursuant to  
258 section 4a-9, not including such expenditures made on behalf of the  
259 Health Systems Planning Unit of the Office of Health Strategy, and the  
260 actual expenditures for the fall prevention program. On or before July  
261 thirty-first, annually, the Insurance Commissioner shall render to each  
262 such domestic insurance company and other domestic entity a  
263 statement showing the difference between their respective recalculated  
264 assessments and the amount they have previously paid. On or before  
265 August thirty-first, the Insurance Commissioner, after receiving any  
266 objections to such statements, shall make such adjustments that in the  
267 commissioner's opinion may be indicated, and shall render an adjusted  
268 assessment, if any, to the affected companies. Any such domestic  
269 insurance company or other domestic entity may pay to the Insurance  
270 Commissioner the entire assessment required under this subsection in  
271 one payment when the first installment of such assessment is due.

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

275 (h) The Insurance Commissioner shall deposit all payments made  
276 under this section with the State Treasurer. On and after June 6, 1991,  
277 the moneys so deposited shall be credited to the Insurance Fund

278 established under section 38a-52a and shall be accounted for as expenses  
279 recovered from insurance companies.

280 Sec. 6. Section 38a-307a of the general statutes is repealed and the  
281 following is substituted in lieu thereof (*Effective from passage*):

282 From July 1, 2004, until the expiration of the Terrorism Insurance  
283 Program established in the federal Terrorism Risk Insurance Act of 2002,  
284 P.L. 107-297, as amended and reauthorized from time to time, [(1) for  
285 any master policy that is required to be purchased by a condominium  
286 association pursuant to section 47-83 or by a unit owners' association  
287 pursuant to section 47-255, the standard form of fire insurance policy set  
288 forth in section 38a-307 shall not exclude coverage for loss by fire or  
289 other perils insured against in the policy caused, directly or indirectly,  
290 by terrorism, as defined by the Insurance Commissioner; and (2)] for  
291 any [other] commercial risk insurance policy, the standard form of fire  
292 insurance policy set forth in section 38a-307 may provide that the  
293 company shall not be liable for loss by fire or other perils insured against  
294 in the policy caused, directly or indirectly, by terrorism, as defined by  
295 the Insurance Commissioner, provided the premiums charged for such  
296 policy shall reflect any savings projected from the exclusion of such  
297 perils.

298 Sec. 7. Subsection (b) of section 38a-323 of the 2026 supplement to the  
299 general statutes is repealed and the following is substituted in lieu  
300 thereof (*Effective January 1, 2027*):

301 (b) (1) A premium billing notice for any policy subject to the  
302 requirements of sections 38a-663 to 38a-696, inclusive, except a workers'  
303 compensation policy, shall be mailed or delivered to the insured by the  
304 insurer or its agent or, if agreed between the insurer and the named  
305 insured, by electronic means, not less than thirty days in advance of the  
306 policy's renewal or anniversary date, except that such notice shall not be  
307 required for a commercial risk policy if the premium for the ensuing  
308 policy period is to increase less than ten per cent on an annual basis. The  
309 premium billing notice for a personal risk insurance policy under  
310 section 38a-663 shall (A) provide, pursuant to subdivision (3) of this

311 subsection, a reasonable explanation for premium increases not later  
312 than twenty days after the named insured requests, in writing,  
313 information about the reasons for such premium increase, (B) be based  
314 on the rates and rules applicable to the ensuing policy period, and [shall]  
315 (C) include a notice of transfer when the policy has been transferred  
316 from an insurer to an affiliate of such insurer pursuant to the provisions  
317 of subparagraph (C) of subdivision (1) of subsection (a) of this section.  
318 As used herein, "reasonable explanation" means sufficient information,  
319 in terms that are understandable to an average policyholder, which  
320 enables the policyholder to determine the basic nature of any premium  
321 increase. The provisions of this subsection shall apply to any such policy  
322 for which the annual premium was less than fifty thousand dollars for  
323 the preceding annual policy period.

324 (2) For purposes of any commercial risk policy subject to the  
325 requirements of sections 38a-663 to 38a-696, inclusive, except a workers'  
326 compensation policy, the mailing or delivery of a premium billing notice  
327 by an insurer's managing general agent, in accordance with the  
328 provisions of subdivision (1) of this subsection, shall constitute  
329 compliance by such insurer with said subdivision.

330 (3) An insurer shall include a prominent statement at the beginning  
331 of the first page of the premium billing notice, or elsewhere provided  
332 such prominent statement is in a format prescribed by the Insurance  
333 Commissioner, for personal risk insurance policies that includes contact  
334 information of the insurer in order that the insured may request  
335 additional information concerning the premium increase.

336 Sec. 8. Subsection (b) of section 38a-323 of the 2026 supplement to the  
337 general statutes is amended by adding subdivision (4) as follows  
338 (*Effective January 1, 2029*):

339 (NEW) (4) On and after July 1, 2029, if the renewal of any personal  
340 risk insurance policy under section 38a-663 has a premium billing  
341 increase of ten per cent or more, the premium billing notice shall  
342 provide the dollar impact or an estimate of the dollar impact of the  
343 increase attributable to each primary factor. If the premium billing

344 notice uses estimated dollars, the insurer shall provide a reasonable  
345 explanation of the degree of accuracy achieved by use of the estimated  
346 dollars. The Insurance Commissioner may authorize an extension of  
347 time for compliance with the provisions of this subdivision, not to  
348 exceed December 1, 2029, if the Insurance Commissioner determines  
349 additional time is necessary for such compliance. The provisions of this  
350 subdivision shall not apply to premium increases of one hundred  
351 dollars or less. The Insurance Commissioner shall adopt regulations, in  
352 accordance with the provisions of chapter 54, to implement the  
353 provision of this subdivision.

354 Sec. 9. Subsection (a) of section 38a-353 of the general statutes is  
355 repealed and the following is substituted in lieu thereof (*Effective from*  
356 *passage*):

357 (a) Whenever any damaged motor vehicle covered under an  
358 automobile insurance policy has been declared to be a constructive total  
359 loss by the insurer, the insurer shall, in calculating the value of such  
360 vehicle for purposes of determining the settlement amount to be paid to  
361 the claimant, use at least the average of the retail values given such  
362 vehicle by (1) the [National Automobile Dealers Association] I.D. Power  
363 used car guide or any other publicly available automobile industry  
364 source that has been approved for such use by the Insurance  
365 Commissioner, and (2) one other automobile industry source that has  
366 been approved for such use by said commissioner. For the purposes of  
367 this section, "constructive total loss" means the cost to repair or salvage  
368 damaged property, or the cost to both repair and salvage such property,  
369 equals or exceeds the total value of the property at the time of loss.

370 Sec. 10. Section 38a-356 of the general statutes is repealed and the  
371 following is substituted in lieu thereof (*Effective October 1, 2026*):

372 (a) Any authorized employee of the Department of Emergency  
373 Services and Public Protection, Department of Motor Vehicles or a local  
374 police department may in writing request any insurance company to  
375 release to such employee information relative to any investigation it has  
376 made concerning a motor vehicle's loss or potential loss or any

377 information relating to fraud or potential fraud in any claim under a  
378 motor vehicle insurance policy. Any insurance company, on its own  
379 initiative, may provide and disclose information relating to fraud or  
380 potential fraud to such authorized persons. Such information shall  
381 include, but not be limited to: (1) An insurance policy relative to such  
382 loss, (2) policy premium records, (3) history of previous claims, and (4)  
383 other relevant material relating to such loss or potential loss or to such  
384 fraud or potential fraud.

385 (b) Any insurance company so requested shall furnish such  
386 information to any such employee and shall permit the Insurance  
387 Commissioner or the commissioner's designee and any person ordered  
388 by a court to inspect its records pertaining to the policy and loss. Any  
389 insurance company may request any such employee to release  
390 information relative to any departmental investigation concerning the  
391 loss. Any information obtained relative to fraud or potential fraud may  
392 be disclosed to any central reporting bureau and any law enforcement  
393 agency.

394 [(c) On or before March thirty-first of each year, each insurance  
395 company shall provide the Insurance Commissioner annual reports  
396 detailing all information received or investigations conducted by such  
397 company during the past year concerning insurance fraud in any claim  
398 under a motor vehicle insurance policy. Such reports shall be filed in a  
399 manner prescribed by the commissioner.]

400 [(d)] (c) In the absence of fraud, malice or criminal act, no insurance  
401 company, authorized employee or person who furnished information  
402 on behalf of such company or department, shall be liable for damages  
403 in a civil action or subject to criminal prosecution for any oral or written  
404 statement made pursuant to the provisions of this section.

405 [(e)] (d) Information furnished pursuant to this section shall be held  
406 in confidence until its release is required pursuant to a criminal or civil  
407 proceeding.

408 Sec. 11. Section 38a-465d of the general statutes is repealed and the

409 following is substituted in lieu thereof (*Effective October 1, 2026*):

410 [(a) On or before March first of each year, each provider shall file with  
411 the commissioner an annual statement containing such information as  
412 the commissioner may prescribe. The commissioner shall adopt  
413 regulations, in accordance with chapter 54, to prescribe the contents of  
414 such annual statement, which shall include, but not be limited to, for  
415 any policy settled within five years of policy issuance, the total number,  
416 aggregate face amount and life settlement proceeds of policies settled  
417 during the immediately preceding calendar year, a breakdown of the  
418 information by policy issue year, the names of the insurance companies  
419 whose policies have been settled and the brokers that have settled said  
420 policies. Such information shall be limited to only those transactions  
421 where the insured is a resident of this state and shall not include  
422 individual transaction data regarding the business of life settlements or  
423 information where there is a reasonable basis to conclude such data or  
424 information could be used to identify the owner or the insured.

425 (b) Each provider that wilfully fails to file an annual statement as  
426 required in this section or wilfully fails to reply not later than thirty days  
427 to a written inquiry by the commissioner in connection therewith, shall,  
428 in addition to other penalties provided by this part, be subject upon due  
429 notice and opportunity to be heard to a penalty of up to two hundred  
430 fifty dollars per day of delay, not to exceed twenty-five thousand dollars  
431 in the aggregate, for each such failure.]

432 [(c)] (a) Except as otherwise required or permitted by law, no person,  
433 including, but not limited to, a provider, broker, insurance company,  
434 insurance producer, information bureau, rating agency or company, or  
435 any other person with actual knowledge of an insured's identity, shall  
436 disclose such identity or information where there is a reasonable basis  
437 to conclude such information could be used to identify the insured or  
438 the insured's financial or medical information to any other person unless  
439 such disclosure: (1) Is necessary to effect a life settlement contract  
440 between the owner and a provider and the owner and insured have  
441 provided prior written consent to such disclosure; (2) is provided in

442 response to an investigation or examination by the commissioner or any  
443 other governmental office or agency or pursuant to the requirements of  
444 section 38a-465i; (3) is necessary to effectuate the sale of life settlement  
445 contracts or interests therein as investments, provided the sale is  
446 conducted in accordance with applicable state and federal securities  
447 laws, and provided further the owner and the insured have both  
448 provided prior written consent to the disclosure; (4) is a term of or  
449 condition to the transfer of a policy by one provider to another provider,  
450 in which case the provider receiving such information shall comply with  
451 the confidentiality requirements specified in this subsection; (5) is  
452 necessary to allow the provider or broker or their authorized  
453 representatives to make contacts for the purpose of determining health  
454 status. For the purpose of this section, "authorized representative" does  
455 not include any person who has or may have a financial interest in the  
456 settlement contract other than a provider, licensed broker, financing  
457 entity, related provider trust or special purpose entity. Each provider or  
458 broker shall require its authorized representative to agree in writing to  
459 comply with the privacy provisions of this part; or (6) is required to  
460 purchase stop loss coverage.

461 [(d)] (b) Nonpublic personal information solicited or obtained in  
462 connection with a proposed or actual life settlement contract shall be  
463 subject to the provisions applicable to financial institutions under the  
464 federal Gramm-Leach-Bliley Act of 1999, P.L. 106-102, as amended from  
465 time to time, and all other applicable state and federal laws relating to  
466 confidentiality of nonpublic personal information.

467 Sec. 12. Section 38a-477jj of the general statutes is repealed and the  
468 following is substituted in lieu thereof (*Effective January 1, 2027*):

469 (a) For the purposes of this section:

470 (1) "Affordable Care Act" has the same meaning as provided in  
471 section 38a-1080;

472 (2) "Exchange" has the same meaning as provided in section 38a-1080;

473 (3) "Health benefit plan" has the same meaning as provided in section  
474 38a-1080, except that such term shall not include a grandfathered health  
475 plan as such term is used in the Affordable Care Act;

476 (4) "Health carrier" has the same meaning as provided in section 38a-  
477 1080;

478 (5) "Office of Health Strategy" means the Office of Health Strategy  
479 established under section 19a-754a; and

480 (6) "Qualified health plan" has the same meaning as provided in  
481 section 38a-1080.

482 (b) Notwithstanding any provision of the general statutes and except  
483 as provided in subsection (c) of this section, no health carrier offering a  
484 health benefit plan in this state on or after January 1, 2022, that includes  
485 a pharmacy benefit and uses a drug formulary or list of covered drugs  
486 may:

487 (1) Remove a prescription drug from the drug formulary or list of  
488 covered drugs during a plan year; or

489 (2) Move a prescription drug from a cost-sharing tier that imposes a  
490 lesser coinsurance, copayment or deductible for the prescription drug to  
491 a cost-sharing tier that imposes a greater coinsurance, copayment or  
492 deductible for the prescription drug during a plan year, unless the  
493 prescription drug is subject to an in-network coinsurance, copayment or  
494 deductible that is not greater than forty dollars per prescription per  
495 month in any tier.

496 (c) A health carrier offering a health benefit plan in this state on or  
497 after January 1, 2022, that includes a pharmacy benefit and uses a drug  
498 formulary or list of covered drugs may during the plan year:

499 (1) Remove a prescription drug from the drug formulary or list of  
500 covered drugs, upon at least ninety days' advance notice to a covered  
501 person and the covered person's treating physician, if:

502 (A) The federal Food and Drug Administration issues an  
503 announcement, guidance, notice, warning or statement concerning the  
504 prescription drug that calls into question the clinical safety of the  
505 prescription drug, unless the covered person's treating physician states,  
506 in writing, that the prescription drug remains medically necessary  
507 despite such announcement, guidance, notice, warning or statement; or

508 (B) The prescription drug is approved by the federal Food and Drug  
509 Administration for use without a prescription; and

510 (2) Move a brand-name prescription drug from a cost-sharing tier  
511 that imposes a lesser coinsurance, copayment or deductible for the  
512 brand-name prescription drug to a cost-sharing tier that imposes a  
513 greater coinsurance, copayment or deductible for the brand-name  
514 prescription drug if the health carrier adds to the drug formulary or list  
515 of covered drugs a generic prescription drug that is:

516 (A) Approved by the federal Food and Drug Administration for use  
517 as an alternative to such brand-name prescription drug; and

518 (B) In a cost-sharing tier that imposes a coinsurance, copayment or  
519 deductible for the generic prescription drug that is lesser than the  
520 coinsurance, copayment or deductible that is imposed for such brand-  
521 name prescription drug.

522 (d) A health carrier offering a health benefit plan in this state on or  
523 after January 1, 2027, that includes a pharmacy benefit and uses a drug  
524 formulary or list of covered drugs may remove a prescription drug from  
525 the drug formulary or list of covered drugs at renewal of a health benefit  
526 plan subject to not less than ninety days' advance notice to a covered  
527 person and the covered person's treating physician.

528 [(d)] (e) Nothing in this section shall prevent or prohibit a health  
529 carrier from adding a prescription drug to a formulary or list of covered  
530 drugs at any time.

531 [(e)] (f) (1) The Office of Health Strategy shall, at least annually,  
532 conduct a study to determine the impact that the requirements

533 established in subsections (a) to [(d)] (e), inclusive, of this section have  
534 on the cost of health benefit plans offered, delivered, issued for delivery,  
535 renewed, amended or continued in this state and qualified health plans  
536 offered and sold through the exchange.

537 (2) Not later than January 31, 2023, and annually thereafter, the Office  
538 of Health Strategy shall submit a report, in accordance with the  
539 provisions of section 11-4a, to the commissioner and the joint standing  
540 committee of the General Assembly having cognizance of matters  
541 relating to insurance. Such report shall disclose the results of the study  
542 conducted pursuant to subdivision (1) of this subsection for the  
543 preceding year.

544 Sec. 13. Subdivision (4) of subsection (e) of section 38a-591g of the  
545 general statutes is repealed and the following is substituted in lieu  
546 thereof (*Effective July 1, 2026*):

547 (4) (A) Not later than one business day after the preliminary review  
548 of an external review request or the day the preliminary review of an  
549 expedited external review request is completed, the health carrier shall  
550 notify the commissioner, the assigned independent review  
551 organization, the covered person and, if applicable, the covered person's  
552 authorized representative in writing whether the request for an external  
553 review or an expedited external review is complete and eligible for such  
554 review. The commissioner may specify the form for the health carrier's  
555 notice of initial determination under this subdivision and any  
556 supporting information required to be included in the notice.

557 (B) If the external review or the expedited external review is accepted,  
558 the health carrier shall notify the commissioner, the covered person and,  
559 if applicable, the covered person's authorized representative in writing  
560 of the request's eligibility and acceptance for external review or  
561 expedited external review. For an external review, the health carrier  
562 shall include in such notice (i) a statement that the covered person or the  
563 covered person's authorized representative may submit, not later than  
564 five business days after the covered person or the covered person's  
565 authorized representative, as applicable, received such notice,

566 additional information in writing to the assigned independent review  
567 organization that such organization shall consider when conducting the  
568 external review, and (ii) where and how such additional information is  
569 to be submitted. If additional information is submitted later than five  
570 business days after the covered person or the covered person's  
571 authorized representative, as applicable, received such notice, the  
572 independent review organization may, but shall not be required to,  
573 accept and consider such additional information.

574 (C) If the request:

575 (i) Is not complete, the health carrier shall notify the commissioner  
576 and the covered person and, if applicable, the covered person's  
577 authorized representative in writing and include in the notice what  
578 information or materials are needed to perfect the request; or

579 (ii) Is not eligible for external review or expedited external review,  
580 the health carrier shall notify the commissioner, the covered person and,  
581 if applicable, the covered person's authorized representative in writing  
582 and include in the notice the reasons for its ineligibility.

583 (D) The notice of initial determination shall include a statement  
584 informing the covered person and, if applicable, the covered person's  
585 authorized representative that a health carrier's initial determination  
586 that the request for an external review or an expedited external review  
587 is ineligible for review may be appealed to the commissioner.

588 (E) Notwithstanding a health carrier's initial determination that a  
589 request for an external review or an expedited external review is  
590 ineligible for review, the commissioner may determine, pursuant to the  
591 terms of the covered person's health benefit plan, that such request is  
592 eligible for such review and assign an independent review organization  
593 to conduct such review. Any such review shall be conducted in  
594 accordance with this section.

595 Sec. 14. Subsection (i) of section 38a-591g of the general statutes is  
596 repealed and the following is substituted in lieu thereof (*Effective July 1,*

597 2026):

598 (i) (1) The independent review organization shall notify the  
599 commissioner, the health carrier, the covered person and, if applicable,  
600 the covered person's authorized representative in writing of its decision  
601 to uphold, reverse or revise the adverse determination or the final  
602 adverse determination, not later than:

603 (A) For external reviews, forty-five calendar days after such  
604 organization receives [the assignment from the commissioner to  
605 conduct such review] notice that the health carrier has completed a  
606 preliminary review of the request and determined that the review is  
607 complete and eligible for review;

608 (B) For external reviews involving a determination that the  
609 recommended or requested health care service or treatment is  
610 experimental or investigational, twenty calendar days after such  
611 organization receives [the assignment from the commissioner to  
612 conduct such review] notice that the health carrier has completed a  
613 preliminary review of the request and determined that the review is  
614 complete and eligible for review;

615 (C) For expedited external reviews, except as specified under  
616 subparagraph (D) of this subdivision, as expeditiously as the covered  
617 person's medical condition requires, but not later than forty-eight hours  
618 after such organization receives [the assignment from the commissioner  
619 to conduct such review] notice that the health carrier has completed a  
620 preliminary review of the request and determined that the review is  
621 complete and eligible for review or seventy-two hours after such  
622 organization receives such [assignment] notice if any portion of such  
623 forty-eight-hour period falls on a weekend;

624 (D) For expedited external reviews involving a health care service or  
625 course of treatment specified under subparagraph (B) or (C) of  
626 subdivision (38) of section 38a-591a, as expeditiously as the covered  
627 person's medical condition requires, but not later than twenty-four  
628 hours after such organization receives [the assignment from the

629 commissioner to conduct such review] notice that the health carrier has  
630 completed a preliminary review of the request and determined that the  
631 review is complete and eligible for review; and

632 (E) For expedited external reviews involving a determination that the  
633 recommended or requested health care service or treatment is  
634 experimental or investigational, as expeditiously as the covered person's  
635 medical condition requires, but not later than five calendar days after  
636 such organization receives [the assignment from the commissioner to  
637 conduct such review] notice that the health carrier has completed a  
638 preliminary review of the request and determined that the review is  
639 complete and eligible for review.

640 (2) Such notice shall include:

641 (A) A general description of the reason for the request for the review;

642 (B) The date the independent review organization received [the  
643 assignment from the commissioner to conduct the review] notice that  
644 the health carrier has completed a preliminary review of the request and  
645 determined that the review is complete and eligible for review;

646 (C) The date the review was conducted;

647 (D) The date the organization made its decision;

648 (E) The principal reason or reasons for its decision, including what  
649 applicable evidence-based standards, if any, were used as a basis for its  
650 decision;

651 (F) The rationale for the organization's decision;

652 (G) Reference to the evidence or documentation, including any  
653 evidence-based standards, considered by the organization in reaching  
654 its decision; and

655 (H) For a review involving a determination that the recommended or  
656 requested health care service or treatment is experimental or  
657 investigational:

- 658 (i) A description of the covered person's medical condition;
- 659 (ii) A description of the indicators relevant to determining whether  
660 there is sufficient evidence to demonstrate that (I) the recommended or  
661 requested health care service or treatment is likely to be more beneficial  
662 to the covered person than any available standard health care services  
663 or treatments, and (II) the adverse risks of the recommended or  
664 requested health care service or treatment would not be substantially  
665 increased over those of available standard health care services or  
666 treatments;
- 667 (iii) A description and analysis of any medical or scientific evidence  
668 considered in reaching the opinion;
- 669 (iv) A description and analysis of any evidence-based standard; and
- 670 (v) Information on whether the clinical peer's rationale for the  
671 opinion is based on the documents and information set forth in  
672 subsection (f) of this section.

673 (3) Upon the receipt of a notice of the independent review  
674 organization's decision to reverse or revise an adverse determination or  
675 a final adverse determination, the health carrier shall immediately  
676 approve the coverage that was the subject of the adverse determination  
677 or the final adverse determination.

678 Sec. 15. Section 38a-708 of the general statutes is repealed and the  
679 following is substituted in lieu thereof (*Effective October 1, 2026*):

680 Upon the request of the Insurance Commissioner, any insurance  
681 company shall furnish to the Insurance Department the facts relative to  
682 the termination of an agent's appointment and the causes thereof. If a  
683 company terminates an agent's appointment for cause, such termination  
684 shall be reported to the commissioner not later than thirty calendar days  
685 after such termination. No agent shall have a cause of action against any  
686 insurance company as a result of such company's having furnished to  
687 said department pursuant to this section any statement, oral or written,  
688 unless such statement is false and was known by such company to be

689 false when made.

690 Sec. 16. Section 38a-720a of the general statutes is repealed and the  
691 following is substituted in lieu thereof (*Effective October 1, 2026*):

692 (a) No person shall offer to act as or hold himself out to be a third-  
693 party administrator in this state unless such person is licensed pursuant  
694 to section 38a-720j, or is exempt from licensure pursuant to subsection  
695 (b) of this section. This requirement shall not apply to a person  
696 employed by a third-party administrator to the extent that such person's  
697 activities are under the supervision and control of the third-party  
698 administrator. The authority granted to a third-party administrator  
699 pursuant to sections 38a-720 to 38a-720i, inclusive, shall not exempt such  
700 third-party administrator's employees from the licensing requirements  
701 of chapters 701b and 702.

702 (b) (1) Any insurer licensed in this state that directly or indirectly  
703 underwrites, collects premiums or charges from, or adjusts or settles  
704 claims for other than its policyholders, subscribers and certificate  
705 holders shall be exempt from sections 38a-720 to 38a-720n, inclusive,  
706 provided such activities only involve the lines of insurance for which  
707 such insurer is licensed in this state. Any such insurer shall (A) be  
708 subject to the provisions of chapter 704, (B) respond to all complaint  
709 inquiries received from the Insurance Department, not later than ten  
710 calendar days after the date a complaint is received by the insurer, and  
711 (C) with respect to any advertising that mentions any customer, obtain  
712 such customer's prior written consent.

713 (2) Nothing in this section shall authorize the commissioner to  
714 regulate a self-insured health plan subject to the Employee Retirement  
715 Income Security Act of 1974. The commissioner is authorized to regulate  
716 those activities an insurer undertakes for the administration of a self-  
717 insured health plan that do not relate to the health benefit plan and that  
718 comport with the commissioner's statutory authority to regulate  
719 insurance and the business of insurance as provided for in 29 USC 1144,  
720 as amended from time to time.

721 (c) No third-party administrator shall act as such without a written  
722 agreement between such third-party administrator and an insurer or  
723 other person utilizing the services of the third-party administrator,  
724 which shall be retained as part of the official records of both the third-  
725 party administrator and such insurer or other person for the duration of  
726 such agreement and for five years thereafter. The agreement shall  
727 contain all provisions required by this section, except insofar as those  
728 provisions that do not apply to the activities performed by the third-  
729 party administrator.

730 (d) The written agreement set forth in subsection (c) of this section  
731 shall include, but not be limited to:

732 (1) A statement of activities that the third-party administrator shall  
733 undertake on behalf of the insurer or other person utilizing the services  
734 of the third-party administrator, and the lines, classes or types of  
735 insurance such third-party administrator is authorized to administer;

736 (2) A statement of the activities and responsibilities of the third-party  
737 administrator regarding the administration of or any standards  
738 pertaining to business underwritten by the insurer, benefits, premium  
739 rates, underwriting criteria or claims payment;

740 (3) A provision requiring the third-party administrator to render an  
741 accounting, on such frequency as the parties agree, that details all  
742 transactions performed by the third-party administrator pertaining to  
743 the business underwritten by the insurer or the business of the person  
744 utilizing the services of the third-party administrator;

745 (4) The procedures for any withdrawals to be made by the third-party  
746 administrator from the fiduciary account established under section 38a-  
747 720f. Such procedures shall address, but not be limited to: (A)  
748 Remittance to an insurer or other person utilizing the services of the  
749 third-party administrator who is entitled to remittance, (B) deposit in an  
750 account maintained in the name of the insurer or other person utilizing  
751 the services of the third-party administrator, (C) transfer to and deposit  
752 in a claims-paying account, with claims to be paid as provided for in

753 subsection (d) of section 38a-720f, (D) payment to a group policyholder  
754 for remittance to the insurer or other person utilizing the services of the  
755 third-party administrator entitled to such remittance, (E) payment to the  
756 third-party administrator for its commissions, fees or charges, and (F)  
757 remittance of return premiums to the person or persons entitled to such  
758 return premiums;

759 (5) Procedures and requirements for the disclosures required to be  
760 made by the third-party administrator under section 38a-720h; [and]

761 (6) A termination provision, by which either party to the written  
762 agreement may terminate such agreement for cause, that includes a  
763 procedure to resolve any disputes regarding the cause for termination  
764 of such agreement; and

765 (7) A provision requiring the third-party administrator to continue to  
766 provide the services contemplated under the agreement in the event of  
767 the insolvency or receivership of the insurer.

768 (e) A third-party administrator or insurer or other person utilizing  
769 the services of the third-party administrator may, with written notice,  
770 terminate the written agreement for cause as provided in such written  
771 agreement. The insurer may suspend the underwriting authority of the  
772 third-party administrator during the pendency of any dispute regarding  
773 the cause for termination of the written agreement. The insurer or other  
774 person utilizing the services of the third-party administrator shall fulfill  
775 any legal obligations with respect to policies or plans affected by the  
776 written agreement, regardless of any dispute between the third-party  
777 administrator and the insurer or other person utilizing the services of  
778 the third-party administrator.

779 (f) No license issued to a third-party administrator shall be renewed  
780 unless the third-party administrator has complied with the  
781 requirements of section 19a-7j, as amended by this act.

782 Sec. 17. Section 38a-720e of the general statutes is repealed and the  
783 following is substituted in lieu thereof (*Effective October 1, 2026*):

784 (a) Each insurer or other person utilizing the services of a third-party  
785 administrator shall be responsible for determining the benefits,  
786 premium rates, underwriting criteria and claims payment procedures  
787 for the lines, classes or types of insurance such third-party administrator  
788 is authorized to administer, and for securing reinsurance, if any. The  
789 insurer or other person utilizing the services of a third-party  
790 administrator shall provide to such third-party administrator, in  
791 writing, procedures pertaining to such third-party administrator's  
792 administration of benefits, premium rates, underwriting criteria and  
793 claims payment. Each insurer or other person utilizing the services of a  
794 third-party administrator shall be responsible for the competent  
795 administration of such insurer's or other person's benefit and service  
796 programs.

797 (b) If a third-party administrator administers benefits for more than  
798 one hundred certificate holders on behalf of an insurer or other person  
799 utilizing the services of a third-party administrator, such insurer or  
800 other person shall, at least semiannually, conduct a review of the  
801 operations of the third-party administrator. [At least one such review  
802 shall be an on-site audit of the operations of the third-party  
803 administrator.]

804 Sec. 18. Subsection (b) of section 38a-792 of the 2026 supplement to  
805 the general statutes is repealed and the following is substituted in lieu  
806 thereof (*Effective October 1, 2026*):

807 (b) The commissioner may prescribe reasonable regulations, in  
808 accordance with the provisions of chapter 54, governing the licensing of  
809 casualty claims adjusters, [and] the adjustment of casualty claims and  
810 the establishment of continuing education requirements for persons  
811 licensed as casualty claims adjusters.

812 Sec. 19. Section 38a-837 of the general statutes is repealed and the  
813 following is substituted in lieu thereof (*Effective October 1, 2026*):

814 Sections 38a-836 to 38a-853, inclusive, shall apply to all kinds of direct  
815 insurance, [except] but shall not be applicable to the following:

- 816 (1) Life, annuity, health or disability insurance;
- 817 (2) Mortgage guaranty, financial guaranty or other forms of insurance  
818 offering protection against investment risks;
- 819 (3) Fidelity or surety or any bonding obligations;
- 820 (4) Credit insurance, vendors' single interest insurance, or collateral  
821 protection insurance or any similar insurance protecting the interests of  
822 a creditor arising out of a creditor-debtor transaction;
- 823 (5) [Insurance] Except for coverages that may be set forth in a  
824 cybersecurity policy, insurance of warranties or service contracts,  
825 including insurance that provides for the repair, replacement or service  
826 of goods or property, or indemnification for repair, replacement or  
827 service, for the operational or structural failure of the goods or property  
828 due to a defect in materials, workmanship or normal wear and tear, or  
829 that provides reimbursement for the liability incurred by the issuer of  
830 agreements or service contracts that provide such benefits;
- 831 (6) Title insurance;
- 832 (7) Ocean marine insurance;
- 833 (8) Any transaction or combination of transactions between a person,  
834 including affiliates of such person, and an insurer, including affiliates of  
835 such insurer, which involves the transfer of investment or credit risk  
836 unaccompanied by transfer of insurance risk;
- 837 (9) Any insurance provided by or guaranteed by government; or
- 838 (10) Flood insurance pursuant to the federal Flood Disaster Protection  
839 Act of 1973, as amended, 42 USC Section 4001, et seq.

840 Sec. 20. Section 38a-838 of the general statutes is repealed and the  
841 following is substituted in lieu thereof (*Effective October 1, 2026*):

842 The following terms as used in sections 38a-836 to 38a-853, inclusive,  
843 unless the context otherwise requires or a different meaning is

844 specifically prescribed, shall have the following meanings:

845 (1) "Account" means any one of the three accounts created by section  
846 38a-839;

847 (2) "Affiliate" means any affiliate, as defined in section 38a-1, of an  
848 insolvent insurer;

849 (3) "Association" means the Connecticut Insurance Guaranty  
850 Association created under section 38a-839;

851 (4) "Commissioner" means the Insurance Commissioner;

852 (5) (A) "Covered claim" means an unpaid claim, including, but not  
853 limited to, one for unearned premiums, that arises out of and is within  
854 the coverage and subject to the applicable limits of an insurance policy  
855 to which sections 38a-836 to 38a-853, inclusive, apply, if such insurer  
856 becomes an insolvent insurer or such claim was assumed as a direct  
857 obligation by an insurer that becomes an insolvent insurer, [where such  
858 obligation was assumed through a merger or an acquisition, pursuant  
859 to an acquisition of assets and assumption of liabilities or pursuant to  
860 an assumption reinsurance transaction,] and (i) the claimant or insured  
861 is a resident of this state at the time of the insured event, or (ii) the claim  
862 is a first party claim for damage to property with a permanent location  
863 in this state. For the purposes of this subparagraph, the residence of a  
864 claimant or an insured that is not an individual shall be the state in  
865 which such claimant's or insured's principal place of business is located  
866 at the time of the insured event. "Covered claim" includes claim  
867 obligations arising from the issuance of an insurance policy by a  
868 member insurer, which are later allocated, transferred, merged into,  
869 novated, assumed by or otherwise made the sole responsibility of  
870 another member or nonmember insurer if all the following conditions  
871 are satisfied: (I) The original member insurer has no remaining  
872 obligations on the policy after the transfer; (II) a final order of  
873 liquidation with a finding of insolvency has been entered against the  
874 insurer that assumed the member insurer's coverage obligations by a  
875 court of competent jurisdiction in the insurer's state of domicile; (III) the

876 claim would have been a covered claim if the claim had remained the  
877 responsibility of the original member insurer and the order of  
878 liquidation had been entered against the original member insurer, with  
879 the same claim submission date and liquidation date; and (IV) in cases  
880 where the member insurer's coverage obligations were assumed by a  
881 nonmember insurer, the transaction received prior regulatory or judicial  
882 approval.

883 (B) "Covered claim" does not include (i) any claim by or for the benefit  
884 of any reinsurer, insurer, insurance pool or underwriting association, as  
885 subrogation recoveries or otherwise, provided a claim for any such  
886 amount, asserted against a person insured under a policy issued by an  
887 insurer that has become an insolvent insurer, that, if it were not a claim  
888 by or for the benefit of a reinsurer, insurer, insurance pool or  
889 underwriting association, would be a "covered claim", may be filed  
890 directly with the receiver of the insolvent insurer but in no event shall  
891 any such claim be asserted against the insured of such insolvent insurer,  
892 (ii) any claim by or on behalf of an individual who is neither a citizen of  
893 the United States nor an alien legally resident in the United States at the  
894 time of the insured event, or an entity other than an individual whose  
895 principal place of business is not in the United States at the time of the  
896 insured event, and it arises out of an accident, occurrence, offense, act,  
897 error or omission that takes place outside of the United States, or a loss  
898 to property normally located outside of the United States or, if a  
899 workers' compensation claim, it arises out of employment outside of the  
900 United States, (iii) any claim by or on behalf of a person who is not a  
901 resident of this state, other than a claim for compensation or any other  
902 benefit that arises out of and is within the coverage of a workers'  
903 compensation policy, against an insured whose net worth at the time  
904 the policy was issued or at any time thereafter exceeded twenty-five  
905 million dollars, provided an insured's net worth for purposes of this  
906 section and section 38a-844 shall be deemed to include the aggregate net  
907 worth of the insured and all of its subsidiaries as calculated on a  
908 consolidated basis, (iv) any claim by or on behalf of an affiliate of the  
909 insolvent insurer at the time the policy was issued or at the time of the  
910 insured event, (v) any claim arising out of a policy issued by an insurer

911 that was not licensed to transact insurance in this state at the time the  
912 policy was issued, when it assumed the obligation for the covered claim  
913 or when the insured event occurred, unless the assumption of the  
914 obligation was effected pursuant to subsection (g) of section 23 of this  
915 act, (vi) any amount due under any policy originally issued by a surplus  
916 lines carrier, risk retention group, self-insurer or group self-insurer, (vii)  
917 any obligation assumed by an insolvent insurer after the  
918 commencement of any delinquency proceeding, as defined in section  
919 38a-905, involving the insolvent insurer or the original insurer, unless it  
920 would have been a covered claim absent such assumption, or (viii) any  
921 obligation assumed by an insolvent insurer in a transaction in which the  
922 original insurer remains separately liable;

923 (6) "Cybersecurity insurance" includes first and third-party coverage,  
924 in a policy or endorsement, written on a direct, admitted basis for losses  
925 and loss mitigation arising out of or relating to data privacy breaches,  
926 unauthorized information network security intrusions, computer  
927 viruses, ransomware, cyber extortion, identity theft and similar  
928 exposures;

929 ~~[(6)]~~ (7) "Insolvent insurer" means an insurer (A) [(i)] licensed to  
930 transact insurance in this state at the time the policy was issued, [when  
931 it assumed the obligation for the covered claim] or when the insured  
932 event occurred, and [(ii)] (B) against which a final order of liquidation  
933 with a finding of insolvency has been entered by a court of competent  
934 jurisdiction in the insurer's state of domicile; [(B) that is (i) the legal  
935 successor of an insurer that was licensed to transact insurance in this  
936 state either at the time the policy was issued or when the insured event  
937 occurred, by reason of a merger, provided such merger is approved by  
938 an insurance regulator having jurisdiction over such merger, and (ii)  
939 against which a final order of liquidation with a finding of insolvency  
940 has been entered by a court of competent jurisdiction in the insurer's  
941 state of domicile; or (C) that (i) succeeds to the policy obligations of an  
942 insurer that was licensed to transact insurance in this state either at the  
943 time the policy was issued or when the insured event occurred, by  
944 reason of a division whereby policies issued by such licensed insurer are

945 allocated to or otherwise become the obligation of a successor insurer,  
946 provided such division is approved (I) in a jurisdiction that allows such  
947 division, and (II) by an insurance regulator having jurisdiction over such  
948 division, and (ii) against which a final order of liquidation with a finding  
949 of insolvency has been entered by a court of competent jurisdiction in  
950 the succeeding insurer's state of domicile. "Insolvent insurer" shall not  
951 be construed to mean any insurer with respect to which an order, decree,  
952 judgment or finding of insolvency, whether permanent or temporary in  
953 nature, or order of rehabilitation or conservation has been issued by a  
954 court of competent jurisdiction prior to October 1, 1971;]

955 [(7)] (8) "Member insurer" means any person who (A) writes any kind  
956 of insurance to which sections 38a-836 to 38a-853, inclusive, apply under  
957 section 38a-837, as amended by this act, including, but not limited to,  
958 the exchange of reciprocal or interinsurance contracts, and (B) is  
959 licensed to transact insurance in this state. An insurer shall cease to be a  
960 member insurer effective on the day following the termination or  
961 expiration of its license to transact the kinds of insurance to which said  
962 sections 38a-836 to 38a-853, inclusive, apply, however such insurer shall  
963 remain liable as a member insurer for any obligations, including  
964 obligations for assessments levied prior to the termination or expiration  
965 of the insurer's license and for assessments levied after the termination  
966 or expiration which relate to any insurer which became an insolvent  
967 insurer prior to the termination or expiration of such insurer's license.  
968 In the case of such insurer, the average of its net direct written premium  
969 for the five calendar years prior to expiration or termination of its  
970 license, whether or not the insurer has net direct written premium in the  
971 year preceding such expiration or termination, shall be used as its  
972 assessment base for any year following such expiration or termination  
973 in which the insurer has no direct written premium;

974 [(8)] (9) "Net direct written premiums" means direct gross premiums  
975 written in this state on insurance policies to which sections 38a-836 to  
976 38a-853, inclusive, apply, less return premiums thereon and dividends  
977 paid or credited to policyholders on such direct business, provided the  
978 term "net direct written premiums" shall not include premiums on any

979 contract between insurers or reinsurers;

980 [(9)] (10) "Person" means an individual, corporation, partnership,  
981 association, joint stock company, business trust, limited liability  
982 company, unincorporated organization, voluntary organization,  
983 governmental entity or other legal entity;

984 [(10)] (11) "Residence" means, when used in reference to a  
985 corporation, its principal place of business; and

986 [(11)] (12) "United States" has the same meaning as provided in  
987 section 38a-1.

988 Sec. 21. Section 38a-841 of the general statutes is repealed and the  
989 following is substituted in lieu thereof (*Effective October 1, 2026*):

990 (a) Said association shall:

991 (1) Be obligated to the extent of the covered claims existing prior to  
992 the determination of insolvency or the entry of a final order of  
993 liquidation with a finding of insolvency, as applicable, and arising  
994 within thirty days after the determination of insolvency or the entry of  
995 such order, or before the policy expiration date if less than thirty days  
996 after the determination or the entry of such order, or before the insured  
997 replaces the policy or causes its cancellation if the insured does so within  
998 thirty days after such determination or entry of such order, provided  
999 such obligation shall be limited as follows: (A) With respect to covered  
1000 claims for unearned premiums [, to one-half of the unearned premium  
1001 on any policy,] subject to a maximum of [two] fifty thousand dollars per  
1002 policy; (B) with respect to covered claims other than for unearned  
1003 premiums and those otherwise specified below, such obligation shall  
1004 include only that amount of each such claim that [is in excess of one  
1005 hundred dollars and] is less than or equal to (i) three hundred thousand  
1006 dollars for claims arising under policies of insurers determined to be  
1007 insolvent prior to October 1, 2007, (ii) four hundred thousand dollars for  
1008 claims arising under policies of insurers determined to be insolvent on  
1009 or after October 1, 2007, and prior to October 1, 2015, and (iii) five

1010 hundred thousand dollars for claims arising under policies of insurers  
1011 against which a final order of liquidation with a finding of insolvency  
1012 has been entered by a court of competent jurisdiction in the insurer's  
1013 state of domicile on or after October 1, 2015; (C) with respect to first-  
1014 party real property claims arising under policies of insurers determined  
1015 to be insolvent on or after June 1, 2026, an amount not exceeding one  
1016 million dollars for claims arising from a single occurrence under a policy  
1017 covering commercial or residential property; (D) in no event shall the  
1018 association be obligated to pay an amount in excess of five hundred  
1019 thousand dollars for all first and third-party claims under a policy or  
1020 endorsement providing, or that is found to provide, cybersecurity  
1021 insurance coverage and arising out of or related to a single insured  
1022 event, regardless of the number of claims made or the number of  
1023 claimants. Said association shall pay the full amount of any such claim  
1024 arising out of a workers' compensation policy, provided in no event  
1025 shall said association be obligated [(I)] (i) to any claimant in an amount  
1026 in excess of the obligation of the insolvent insurer under the policy form  
1027 or coverage from which the claim arises, or [(II)] (ii) for any claim filed  
1028 with the association after the expiration of two years from the date of  
1029 the declaration of insolvency unless such claim arose out of a workers'  
1030 compensation policy and was timely filed in accordance with section 31-  
1031 294c;

1032 (2) Be deemed the insurer to the extent of its obligations on the  
1033 covered claims and to such extent shall have all rights, duties, and  
1034 obligations of the insolvent insurer as if the insurer had not become  
1035 insolvent, including, but not limited to, the right to pursue and retain  
1036 salvage and subrogation recoverable on covered claim obligations to the  
1037 extent paid by the association, provided the association shall not be  
1038 deemed the insolvent insurer for the purpose of conferring jurisdiction;

1039 (3) Allocate claims paid and expenses incurred among the three  
1040 accounts, created by section 38a-839, separately, and assess member  
1041 insurers separately (A) in respect of each such account for such amounts  
1042 as shall be necessary to pay the obligations of said association under  
1043 subdivision (1) of this subsection subsequent to an insolvency; (B) the

1044 expenses of handling covered claims subsequent to an insolvency; (C)  
1045 the cost of examinations under section 38a-846; and (D) such other  
1046 expenses as are authorized by sections 38a-836 to 38a-853, inclusive. The  
1047 assessments of each member insurer shall be in the proportion that the  
1048 net direct written premiums of such member insurer for the calendar  
1049 year preceding the assessment on the kinds of insurance in such account  
1050 bears to the net direct written premiums of all member insurers for the  
1051 calendar year preceding the assessment on the kinds of insurance in  
1052 such account. Each member insurer shall be notified of its assessment  
1053 not later than thirty days before it is due. No member insurer may be  
1054 assessed in any year on any account an amount greater than two per  
1055 cent of that member insurer's net direct written premiums for the  
1056 calendar year preceding the assessment on the kinds of insurance in said  
1057 account, provided if, at the time an assessment is levied on the all other  
1058 insurance account, as defined in subdivision (3) of section 38a-839, the  
1059 board of directors finds that at least fifty per cent of the total net direct  
1060 written premiums of a member insurer and all its affiliates, for the year  
1061 on which such assessment is based, were from policies issued or  
1062 delivered in Connecticut, on risks located in this state, such member  
1063 insurer shall be assessed only on such member insurer's net direct  
1064 written premium that is attributable to the kind of insurance that gives  
1065 rise to each covered claim. If the maximum assessment, together with  
1066 the other assets of said association in any account, does not provide in  
1067 any one year in any account an amount sufficient to make all necessary  
1068 payments from that account, the funds available may be prorated and  
1069 the unpaid portion shall be paid as soon thereafter as funds become  
1070 available. Said association may defer, in whole or in part, the assessment  
1071 of any member insurer if the assessment would cause the member  
1072 insurer's financial statement to reflect amounts of capital or surplus less  
1073 than the minimum amounts required for a certificate of authority by any  
1074 jurisdiction in which the member insurer is authorized to transact  
1075 insurance, provided during the period of deferment, no dividends shall  
1076 be paid to shareholders or policyholders. Deferred assessments shall be  
1077 paid when such payment will not reduce capital or surplus below the  
1078 minimum amounts required for a certificate of authority. Such

1079 payments shall be refunded to those insurers receiving greater  
1080 assessments because of such deferment or, at the election of the insurer,  
1081 be credited against future assessments. Each member insurer serving as  
1082 a servicing facility may set off against any assessment, authorized  
1083 payments made on covered claims and expenses incurred in the  
1084 payment of such claims by such member insurer if they are chargeable  
1085 to the account in respect of which the assessment is made;

1086 (4) Investigate claims brought against said association and adjust,  
1087 compromise, settle, and pay covered claims to the extent of said  
1088 association's obligations and deny all other claims. The association shall  
1089 pay claims in any order it deems reasonable including, but not limited  
1090 to, payment in the order of receipt or by classification. It may review  
1091 settlements, releases and judgments to which the insolvent insurer or its  
1092 insureds were parties to determine the extent to which such settlements,  
1093 releases and judgments may be properly contested;

1094 (5) Notify such persons as the commissioner may direct under  
1095 subdivision (1) of subsection (b) of section 38a-843;

1096 (6) Handle claims through its employees or through one or more  
1097 insurers or other persons designated by said association as servicing  
1098 facilities, provided such designation of a servicing facility is approved  
1099 by the commissioner and may be declined by a member insurer;

1100 (7) Reimburse each such servicing facility for obligations of said  
1101 association paid by such facility and for expenses incurred by such  
1102 facility while handling claims on behalf of said association and shall pay  
1103 such other expenses of said association as are authorized by sections  
1104 38a-836 to 38a-853, inclusive.

1105 (b) Said association may: (1) Employ or retain such persons as are  
1106 necessary to handle claims and perform other duties of said association  
1107 and shall have the right to appoint and direct legal counsel retained  
1108 under liability insurance policies for the defense of covered claims and  
1109 to appoint and direct other service providers for covered services; (2)  
1110 borrow such funds as may be necessary from time to time to effect the

1111 purposes of sections 38a-836 to 38a-853, inclusive, in accord with the  
1112 plan of operation under section 38a-842; (3) sue or be sued; (4) intervene  
1113 as a matter of right as a party in any proceeding before any court in this  
1114 state that has jurisdiction over an insolvent insurer, as defined in section  
1115 38a-838, as amended by this act; (5) negotiate and become a party to such  
1116 contracts as are necessary to carry out the purpose of sections 38a-836 to  
1117 38a-853, inclusive; (6) perform such other acts as are necessary or proper  
1118 to effectuate the purpose of said sections; (7) refund to the member  
1119 insurers in proportion to the contribution of each such member insurer  
1120 to that account, that amount by which the assets of the account exceed  
1121 the liabilities, if, at the end of any calendar year, the board of directors  
1122 finds that the assets of said association in any account exceed the  
1123 liabilities of that account as estimated by the board of directors for the  
1124 coming year.

1125 (c) (1) Each insurer paying an assessment under sections 38a-836 to  
1126 38a-853, inclusive, may offset one hundred per cent of the amount of  
1127 such assessment against its premium tax liability to this state under  
1128 chapter 207. Such offset shall be taken over a period of the five  
1129 successive tax years following the year of payment of the assessment, at  
1130 the rate of twenty per cent per year of the assessment paid to the  
1131 association. Each insurer to which has been refunded by the association,  
1132 pursuant to subsection (b) of this section, all or a portion of an  
1133 assessment previously paid to the association by the insurer shall be  
1134 required to pay to the Department of Revenue Services an amount equal  
1135 to the total amount that has been claimed as an offset against the  
1136 premiums tax liability on the premiums tax return or returns, as the case  
1137 may be, filed by such insurer and that is attributable to such refunded  
1138 assessment, provided the amount required to be paid to said  
1139 department shall not exceed the amount of the refunded assessment. If  
1140 the amount of the refunded assessment exceeds the total amount that  
1141 has been claimed as an offset against the premiums tax liability on the  
1142 premiums tax return or returns filed by such insurer and that is  
1143 attributable to such refunded assessment, such excess may not be  
1144 claimed as an offset against the premiums tax liability on a premiums  
1145 tax return or returns filed by such insurer or, if the offset has been

1146 transferred to another person pursuant to subdivision (2) of this  
1147 subsection, by such other person. For purposes of this subparagraph, if  
1148 the offset has been transferred to another person pursuant to  
1149 subdivision (2) of this subsection, the total amount that has been claimed  
1150 as an offset against the premiums tax liability on the premiums tax  
1151 return or returns filed by such insurer includes the total amount that has  
1152 been claimed as an offset against the premiums tax liability on the  
1153 premiums tax return or returns filed by such other person. The  
1154 association shall promptly notify the Commissioner of Revenue Services  
1155 of the name and address of the insurers to which such refunds have been  
1156 made, the amount of such refunds and the date on which such refunds  
1157 were mailed to such insurer. If the amount that an insurer is required to  
1158 pay to the Department of Revenue Services has not been so paid on or  
1159 before the forty-fifth day after the date of mailing of such refunds, the  
1160 insurer shall be liable for interest on such amount at the rate of one per  
1161 cent per month or fraction thereof from such forty-fifth day to the date  
1162 of payment.

1163 (2) An insurer, in this subparagraph called "the transferor", may  
1164 transfer any offset provided under subdivision (1) of this subsection to  
1165 an affiliate, as defined in section 38a-1, of the transferor. Any such  
1166 transfer of the offset by the transferor and any subsequent transfer or  
1167 transfers of the same offset shall not affect the obligation of the  
1168 transferor to pay to the Department of Revenue Services any sums  
1169 which are acquired by refund from the association pursuant to  
1170 subsection (b) of this section and which are required to be paid to the  
1171 Department of Revenue Services pursuant to subdivision (1) of this  
1172 subsection. Such offset may be taken by any transferee only against the  
1173 transferee's premium tax liability to this state under chapter 207. The  
1174 Commissioner of Revenue Services shall not allow such offset to a  
1175 transferee against its premium tax liability unless the transferor, the  
1176 affiliate to which the offset was originally transferred, each subsequent  
1177 transferor and each subsequent transferee have filed such information  
1178 as may be required on forms provided by said commissioner with  
1179 respect to any such transfer or transfers on or before the due date of the  
1180 premium tax return on which such offset would have been taken by the

1181 transferor if no transfer had been made by the transferor.

1182 Sec. 22. Subsection (a) of section 38a-860 of the general statutes is  
1183 repealed and the following is substituted in lieu thereof (*Effective October*  
1184 *1, 2026*):

1185 (a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for  
1186 the policies and contracts specified in subsection (f) of this section: (1)  
1187 To any person, except for a nonresident certificate holder under a group  
1188 policy or contract, who is the beneficiary, assignee or payee, including a  
1189 health care provider rendering services covered under a health  
1190 insurance policy or certificate, of the person covered under subdivision  
1191 (2) of this subsection, regardless of where the person resides, and (2) any  
1192 person who is the owner of, or certificate holder or enrollee under, such  
1193 policy or contract, other than an unallocated annuity contract or a  
1194 structured settlement annuity, and in each case who (A) is a resident, or  
1195 (B) is not a resident, provided (i) the member insurer that issued such  
1196 policy or contract is domiciled in this state, (ii) the state in which the  
1197 person resides has an association similar to the association created by  
1198 this section and sections 38a-837, 38a-838, as amended by this act, 38a-  
1199 845, 38a-853, 38a-859, 38a-862, 38a-863, 38a-865, and 38a-866, and (iii) the  
1200 person is not eligible for coverage by an association in any other state  
1201 because the insurer was not licensed in the state in which the person  
1202 resides at the time specified in the state's guaranty association law,  
1203 unless the assumption of the obligation was effected pursuant to  
1204 subsection (g) of section 23 of this act.

1205 Sec. 23. (NEW) (*Effective October 1, 2026*) (a) As used in this section:

1206 (1) "Assuming insurer" means the insurer that acquires an insurance  
1207 obligation or risk, or both, from the transferring insurer pursuant to an  
1208 assumption reinsurance agreement.

1209 (2) "Assumption reinsurance agreement" means any contract that (A)  
1210 transfers insurance obligations or risks, or both, of existing or in-force  
1211 contracts of insurance from a transferring insurer to an assuming  
1212 insurer, and (B) is intended to effect a novation of the transferred

1213 contract of insurance with the result that the assuming insurer becomes  
1214 directly liable to the policyholders of the transferring insurer and the  
1215 transferring insurer's insurance obligations or risks, or both, under the  
1216 contracts are extinguished.

1217 (3) "Contract of insurance" means any written agreement between an  
1218 insurer and policyholder pursuant to which the insurer, in exchange for  
1219 premium or other consideration, agrees to assume an obligation or risk,  
1220 or both, of the policyholder or to make payments on behalf of, or to, the  
1221 policyholder or its beneficiaries. "Contract of insurance" includes all  
1222 property, casualty, life, health, accident, surety, title and annuity  
1223 business authorized to be written pursuant to the insurance laws of the  
1224 state.

1225 (4) "Home service business" means an insurance business for which  
1226 premiums are collected on a weekly or monthly basis by an agent of the  
1227 insurer.

1228 (5) "Notice of transfer" means the written notice to policyholders  
1229 required by subsection (c) of this section.

1230 (6) "Policyholder" means any individual or entity that has the right to  
1231 terminate or otherwise alter the terms of a contract of insurance.  
1232 "Policyholder" includes any certificate holder whose certificate is in  
1233 force on the proposed effective date of the assumption, if the certificate  
1234 holder has the right to keep the certificate in force without change in  
1235 benefit following termination of the group policy. The right to keep the  
1236 certificate in force referred to in this section shall not include the right  
1237 to elect individual coverage under the Consolidated Omnibus Budget  
1238 Reconciliation Act, Section 601, et seq., of the Employee Retirement  
1239 Income Security Act of 1974, as amended (29 USC 1161 et seq.).

1240 (7) "Transferring insurer" means the insurer that transfers an  
1241 insurance obligation or risk, or both, to an assuming insurer pursuant to  
1242 an assumption reinsurance agreement.

1243 (b) (1) This section applies to any insurer authorized in the state that

1244 either assumes or transfers the obligations or risks, or both, on contracts  
1245 of insurance pursuant to an assumption reinsurance agreement.

1246 (2) This section does not apply to:

1247 (A) Any reinsurance agreement or transaction in which the ceding  
1248 insurer continues to remain directly liable for its insurance obligations  
1249 or risks, or both, under the contracts of insurance subject to the  
1250 reinsurance agreement;

1251 (B) The substitution of one insurer for another upon the expiration of  
1252 insurance coverage pursuant to statutory or contractual requirements  
1253 and the issuance of a new contract of insurance by another insurer;

1254 (C) The transfer of contracts of insurance pursuant to mergers or  
1255 consolidations of two or more insurers to the extent that those  
1256 transactions are regulated by statute;

1257 (D) Any insurer subject to a judicial order of liquidation or  
1258 rehabilitation;

1259 (E) Any reinsurance agreement or transaction to which a state  
1260 insurance guaranty association is a party, provided policyholders do not  
1261 lose any rights or claims afforded under their original policies pursuant  
1262 to chapter 704a of the general statutes; or

1263 (F) The transfer of liabilities from one insurer to another under a  
1264 single group policy upon the request of the group policyholder.

1265 (c) (1) The transferring insurer shall provide or cause to be provided  
1266 to each policyholder a notice of transfer by first-class mail, addressed to  
1267 the policyholder's last-known address or to the address to which  
1268 premium notices or other policy documents are sent or, with respect to  
1269 home service business, by personal delivery with acknowledged receipt.  
1270 A notice of transfer shall also be sent to the transferring insurer's agents  
1271 or brokers of record on the affected policies.

1272 (2) The notice of transfer shall state or provide:

1273 (A) The date the transfer and novation of the policyholder's contract  
1274 of insurance is proposed to take place;

1275 (B) The name, address and telephone number of the assuming and  
1276 transferring insurer;

1277 (C) That the policyholder has the right to either consent to or reject  
1278 the transfer and novation;

1279 (D) The procedures and time limit for consenting to or rejecting the  
1280 transfer and novation;

1281 (E) A summary of any effect that consenting to or rejecting the  
1282 transfer and novation will have on the policyholder's rights;

1283 (F) A statement that the assuming insurer is licensed to write the type  
1284 of business being assumed in the state where the policyholder resides,  
1285 or is otherwise authorized, as provided herein, to assume such business;

1286 (G) The name and address of the person at the transferring insurer to  
1287 whom the policyholder should send its written statement of acceptance  
1288 or rejection of the transfer and novation;

1289 (H) The address and telephone number of the insurance department  
1290 where the policyholder resides such that the policyholder may write or  
1291 call the insurance department for further information regarding the  
1292 financial condition of the assuming insurer; and

1293 (I) The following financial data for both companies:

1294 (i) Ratings for the previous five years, if available, or for such lesser  
1295 period as is available from two nationally recognized insurance rating  
1296 services acceptable to the commissioner, including the rating service's  
1297 explanation of the meaning of the ratings. If ratings are unavailable for  
1298 any year of the five-year period, the following shall additionally be  
1299 disclosed;

1300 (ii) A balance sheet as of December thirty-first for the previous three  
1301 years, if available, or for such lesser period as is available and as of the

1302 date of the most recent quarterly statement;

1303 (iii) A copy of the management's discussion and analysis that was  
1304 filed as a supplement to the previous year's annual statement; and

1305 (iv) An explanation of the reason for the transfer.

1306 (3) Notice in a form prescribed by the commissioner under subsection  
1307 (h) of this section or a substantially similar notice shall be deemed to  
1308 comply with the requirements of subdivision (2) of subsection (c) of this  
1309 section.

1310 (4) The notice of transfer shall include a pre-addressed, postage-paid  
1311 response card that a policyholder may return as its written statement of  
1312 acceptance or rejection of the transfer and novation.

1313 (5) The notice of transfer shall be filed as part of the prior approval  
1314 requirement set forth in subdivision (1) of subsection (d) of this section.

1315 (d) (1) Prior approval by the commissioner is required for any  
1316 transaction where an insurer domiciled in this state assumes or transfers  
1317 obligations or risks, or both, on contracts of insurance under an  
1318 assumption reinsurance agreement. No insurer licensed in this state  
1319 shall transfer obligations or risks, or both, on contracts of insurance  
1320 issued to or owned by residents of this state to any insurer that is not  
1321 licensed in this state. An insurer domiciled in this state shall not assume  
1322 obligations or risks, or both, on contracts of insurance issued to or  
1323 owned by policyholders residing in any other state unless it is licensed  
1324 in the other state, or the insurance regulatory official of that state has  
1325 approved the assumption.

1326 (2) Any licensed foreign insurer that enters into an assumption  
1327 reinsurance agreement that transfers the obligations or risks, or both, on  
1328 contracts of insurance issued to or owned by residents of this state shall  
1329 file or cause to be filed with the commissioner of insurance of this state  
1330 the assumption certificate, a copy of the notice of transfer and an  
1331 affidavit that the transaction is subject to substantially similar  
1332 requirements in the state of domicile of both the transferring and

1333 assuming insurer. If no such requirements exist in the domicile of either  
1334 the transferring or assuming insurers, the requirements of subdivision  
1335 (3) of subsection (d) of this section shall apply.

1336 (3) Any licensed foreign insurer that enters into an assumption  
1337 reinsurance agreement that transfers the obligations or risks, or both, on  
1338 contracts of insurance issued to or owned by residents of this state shall  
1339 obtain prior approval of the Insurance Commissioner and be subject to  
1340 all other requirements of this section with respect to residents of this  
1341 state, unless the transferring and assuming insurers are subject to  
1342 assumption reinsurance requirements adopted by statute or regulation  
1343 in the jurisdiction of their domicile that are substantially similar to those  
1344 contained herein.

1345 (4) The following factors, along with such other factors as the  
1346 commissioner deems appropriate under the circumstances, shall be  
1347 considered by the commissioner in reviewing a request for approval:

1348 (A) The financial condition of the transferring and assuming insurers  
1349 and the effect the transaction will have on the financial condition of each  
1350 company;

1351 (B) The competence, experience and integrity of those persons who  
1352 control the operation of the assuming insurer;

1353 (C) The plans or proposals the assuming party has with respect to the  
1354 administration of the policies subject to the proposed transfer;

1355 (D) Whether the transfer is fair and reasonable to the policyholders  
1356 of both companies; and

1357 (E) Whether the notice of transfer to be provided by the insurer is fair,  
1358 adequate and not misleading.

1359 (e) (1) Policyholders shall have the right to reject the transfer and  
1360 novation of their contracts of insurance. Policyholders electing to reject  
1361 the assumption transaction shall return to the transferring insurer the  
1362 pre-addressed, postage-paid response card or other written notice and

1363 indicate thereon that the assumption is rejected (collectively referred to  
1364 as the "Response Card").

1365 (2) Payment of any premium to the assuming company during the  
1366 twenty-four-month period after notice is received shall be deemed to  
1367 indicate the policyholder's acceptance of the transfer to the assuming  
1368 insurer and a novation shall be deemed to have been effected, provided  
1369 the premium notice clearly states that payment of the premium to the  
1370 assuming insurer shall constitute acceptance of the transfer. The  
1371 premium notice shall also provide a method for the policyholder to pay  
1372 the premium while reserving the right to reject the transfer. With respect  
1373 to any home service business or any other business not using premium  
1374 notices, the disclosures and procedural requirements of this subsection  
1375 shall be set forth in the notice of transfer required by subsections (c) and  
1376 (d) of this section and in the assumption certificate.

1377 (3) Not less than twenty-four months after the mailing of the initial  
1378 notice of transfer required under subsection (c) of this section, if positive  
1379 consent to, or rejection of, the transfer and assumption has not been  
1380 received or consent has not been deemed to have occurred under  
1381 subdivision (2) of subsection (e) of this section, the transferring  
1382 company shall send to the policyholder a second and final notice of  
1383 transfer as specified in subsection (c) of this section. If the policyholder  
1384 does not accept or reject the transfer during the one-month period  
1385 immediately following the date on which the transferring insurer mails  
1386 the second and final notice of transfer, the policyholder's consent shall  
1387 be deemed to have occurred and novation of the contract shall be  
1388 effected. With respect to the home service business, or any other  
1389 business not using premium notices, the twenty-four and one-month  
1390 periods shall be measured from the date of delivery of the notice of  
1391 transfer pursuant to subdivision (1) of subsection (c) of this section.

1392 (4) The transferring insurer shall be deemed to have received the  
1393 response card on the date it is postmarked. A policyholder may also  
1394 send its response card by facsimile or other electronic transmission or  
1395 by registered mail, express delivery or courier service, in which case the

1396 response card shall be deemed to have been received by the assuming  
1397 insurer on the date of actual receipt by the transferring insurer.

1398 (f) If a policyholder consents to the transfer pursuant to subsection (e)  
1399 of this section or if the transfer is effected under subsection (g) of this  
1400 section, there shall be a novation of the contract of insurance subject to  
1401 the assumption reinsurance agreement. A novation pursuant to this  
1402 subsection shall result in (1) the transferring insurer being relieved of all  
1403 insurance obligations or risks, or both, transferred under the  
1404 assumption reinsurance agreement, and (2) the assuming insurer being  
1405 directly and solely liable to the policyholder for those insurance  
1406 obligations or risks, or both.

1407 (g) If an insurer domiciled in this state or in a jurisdiction having a  
1408 substantially similar law is deemed by the domiciliary commissioner to  
1409 be in hazardous financial condition or an administrative proceeding has  
1410 been instituted against it for the purpose of reorganizing or conserving  
1411 the insurer, and the transfer of the contracts of insurance is in the best  
1412 interest of the policyholders, as determined by the domiciliary  
1413 commissioner, a transfer and novation may be effected notwithstanding  
1414 the provisions of this section, including, but not limited to, a form of  
1415 implied consent and adequate notification to the policyholder of the  
1416 circumstances requiring the transfer as approved by the commissioner.

1417 (h) The commissioner may adopt regulations, in accordance with  
1418 chapter 54 of the general statutes, to establish the form of notice of  
1419 transfer required in this section.

1420 Sec. 24. Section 38a-66 of the general statutes is repealed. (*Effective*  
1421 *October 1, 2026*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2026</i>	38a-26
Sec. 2	<i>October 1, 2026</i>	38a-774
Sec. 3	<i>October 1, 2026</i>	51-344b
Sec. 4	<i>October 1, 2026</i>	19a-7j(b)(5)

Sec. 5	<i>October 1, 2026</i>	38a-48
Sec. 6	<i>from passage</i>	38a-307a
Sec. 7	<i>January 1, 2027</i>	38a-323(b)
Sec. 8	<i>January 1, 2029</i>	38a-323(b)(4)
Sec. 9	<i>from passage</i>	38a-353(a)
Sec. 10	<i>October 1, 2026</i>	38a-356
Sec. 11	<i>October 1, 2026</i>	38a-465d
Sec. 12	<i>January 1, 2027</i>	38a-477jj
Sec. 13	<i>July 1, 2026</i>	38a-591g(e)(4)
Sec. 14	<i>July 1, 2026</i>	38a-591g(i)
Sec. 15	<i>October 1, 2026</i>	38a-708
Sec. 16	<i>October 1, 2026</i>	38a-720a
Sec. 17	<i>October 1, 2026</i>	38a-720e
Sec. 18	<i>October 1, 2026</i>	38a-792(b)
Sec. 19	<i>October 1, 2026</i>	38a-837
Sec. 20	<i>October 1, 2026</i>	38a-838
Sec. 21	<i>October 1, 2026</i>	38a-841
Sec. 22	<i>October 1, 2026</i>	38a-860(a)
Sec. 23	<i>October 1, 2026</i>	New section
Sec. 24	<i>October 1, 2026</i>	Repealer section

**INS**      *Joint Favorable Subst.*

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

**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 27 \$	FY 28 \$
Insurance Dept.	IF - Savings	30,000	40,000

Note: IF=Insurance Fund

**Municipal Impact:** None

**Explanation**

The bill allows the Insurance Department to use electronic delivery for certain notices, resulting in savings of approximately \$30,000 for the partial year in FY 27 and \$40,000 in FY 28 and annually thereafter.

The bill additionally makes numerous technical changes to the insurance statutes that result in no fiscal impact to the state.

**The Out Years**

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation and number of notices.

**OLR Bill Analysis****sHB 5373****AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDATIONS FOR REVISIONS TO THE INSURANCE STATUTES.**

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*Allows the insurance commissioner to deliver license suspension and revocation notices electronically*

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*Establishes an objection process for the health and welfare fee that the insurance commissioner assesses against certain insurers, HMOs, and TPAs*

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§§ 7 & 8 — PREMIUM BILLING NOTICES

*Allows certain premium billing notices to be delivered electronically; requires insurers to give a (1) reasonable explanation for premium increases for personal risk policies upon written request and (2) dollar amount (or estimate) of the increase attributable to each primary factor for personal risk policies with a premium increase of at least 10%*

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*Makes a technical change to a provision on settlement amounts for totaled vehicles by replacing a reference to the National Automobile Dealers Association's used car guide with J.D. Power's guide to reflect J.D. Power's acquisition of NADA's used car valuation service; eliminates an annual reporting requirement for automobile insurance fraud investigations*

§ 11 — VIATICAL SETTLEMENT REPORTING

*Eliminates the requirement under current law that viatical settlement providers file an annual statement on settled insurance policies with the insurance commissioner*

**§ 12 — NOTIFICATION OF FORMULARY CHANGES**

*Requires health carriers to provide at least 90 days advance notice to covered individuals and their treating physicians when removing a prescription drug from a formulary at the time of the plan's renewal*

**§§ 13 & 14 — EXTERNAL REVIEW PROCESS DEADLINES AND NOTIFICATION**

*Requires health carriers to notify independent review organizations when their preliminary review of an external adverse determination review is complete; starts the clock for a final external review decision notice generally when the independent review organization receives the carrier's notice*

**§ 15 — REPORTING AGENT TERMINATIONS**

*Requires insurers to report agent terminations for cause to the insurance commissioner within 30 days after the termination*

**§§ 16 & 17 — THIRD-PARTY ADMINISTRATORS**

*Requires contracts between TPAs and insurers to include a provision requiring the TPA to continue services if the insurer is insolvent or in receivership; prohibits the insurance commissioner from renewing a TPA license until the TPA pays existing law's health and welfare fee; allows insurers to conduct semi-annual reviews of TPAs remotely*

**§ 18 — CASUALTY CLAIMS ADJUSTERS CONTINUING EDUCATION REQUIREMENT**

*Allows the commissioner to make regulations to establish continuing education requirements for licensed casualty claims adjusters*

**§§ 19-22 — CONNECTICUT INSURANCE GUARANTY ASSOCIATION**

*Makes changes to CIGA (which generally protects insureds in the state if certain property and casualty insurers fail) to include cybersecurity insurance policies, increase first-party real property coverage and unearned premium maximum claim amounts, and allow certain guaranty association powers and protections, among other things*

**§§ 23 & 24 — NAIC'S ASSUMPTION REINSURANCE MODEL LAW**

*Implements the NAIC Assumption Reinsurance Model Law, including (1) notice requirements for assumption reinsurance transactions; (2) policyholder rights under assumption reinsurance agreements, including the right to reject the transfer; and (3) the insurance commissioner's discretion when an insurer is in a hazardous financial condition*

**SUMMARY**

This bill makes several unrelated changes to the insurance statutes, as described in the section-by-section analysis below.

EFFECTIVE DATE: October 1, 2026, except as specified below.

**§ 1 — SERVICE OF PROCESS NOTICES**

*Allows the insurance commissioner to serve notice of process electronically, instead of only by registered or certified mail as under current law*

By law, the insurance commissioner acts as agent for service of legal

process on specified insurance companies and related entities. The bill allows the commissioner, upon receipt, to send a copy of the legal process to the person to be served electronically, instead of only by registered or certified mail as under current law.

Under existing law and the bill, the commissioner must send a copy of the legal notice to the following individuals: (1) the person to be served at his or her last-known business or personal address; (2) for foreign insurance companies, the secretary or designee; (3) for alien insurance companies, the U.S. resident manager (if any); and (4) for fraternal benefit societies, the secretary or corresponding officer.

The bill requires the commissioner, when sending these copies electronically, to send them to the last known email address on file for the individuals listed above.

## **§§ 2 & 3 — LICENSE SUSPENSION AND REVOCATION NOTICES**

*Allows the insurance commissioner to deliver license suspension and revocation notices electronically*

By law, the insurance commissioner, after notice and a hearing, may suspend or revoke a licensee's license for cause. The bill allows the commissioner, regardless of the Uniform Administrative Procedure Act (UAPA), to send suspension or revocation notices by personal delivery.

By law, "personal delivery" is direct delivery to the intended recipient (or the recipient's designated representative), including electronic delivery to an email address the recipient identified as an acceptable means of communication. Current law requires notice by mail.

The bill specifies that electronic suspension or revocation notices are deemed an acceptable means of communication when sent to a licensee or registrant as follows:

1. to an entity's (firm, association, or corporation) designated primary contact person's email address and
2. to an individual licensee's or registrant's email address.

Under the bill, a notice sent this way is deemed received by the primary contact person or individual on the actual date it was received, or seven days after the date the notice is postmarked or emailed, whichever is earlier.

As under existing law, anyone aggrieved by the commissioner's decision to suspend or revoke a license or registration may appeal to the New Britain Superior Court under the UAPA.

#### **§ 4 — OBJECTION PROCESS FOR HEALTH AND WELFARE FEE**

*Establishes an objection process for the health and welfare fee that the insurance commissioner assesses against certain insurers, HMOs, and TPAs*

By law, the insurance department assesses a health and welfare fee against (1) domestic insurers and HMOs doing business in the state and (2) licensed third-party administrators (TPAs) and domestic insurers not subject to TPA licensure servicing self-insured health benefit plans. The fee is used to pay the expenses of the Department of Public Health's (DPH) Connecticut Vaccine Program (for example, purchasing and distributing childhood vaccines and administering the immunization information system).

The bill establishes an objection process for the health and welfare fee that is similar to existing law's process for the public health fee (a separate assessment that pays for certain other DPH programs, such as children's health initiatives, AIDS services, and tuberculosis care). More specifically, it allows domestic insurers, HMOs, TPAs, and exempt insurers to submit to the insurance commissioner objections to the proposed fee annually, by December 20. The commissioner must then submit to the objector a final statement, by January 1, that includes any adjustments to the fee he deems necessary.

Under existing law, unchanged by the bill, insurers must pay the health and welfare fee by February 1.

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**§ 5 — INSURANCE FUND**

*Adds the Office of the Behavioral Health Advocate to the offices covered by the Insurance Fund general assessment; pushes back several reporting dates in the general assessment process; changes the installment payment amounts as a percentage of the total assessment*

**Office of the Behavioral Health Advocate**

By law, domestic insurers and HMOs pay an annual general assessment to the Insurance Fund to cover the expenses of the Connecticut Insurance Department (CID), Office of the Healthcare Advocate (OHA), and Office of Health Strategy (OHS), among other things. The bill adds the Office of the Behavioral Health Advocate (OBHA) to the list of entities the assessment covers.

Correspondingly, it adds OBHA to (1) statements the insurance commissioner gives to insurers and HMOs showing appropriations for offices covered by the general assessment, (2) calculations that set the assessment, and (3) calculations to determine the upper limit for insurers' and HMO's required payments as a percentage of office expenditures.

**Reporting Dates**

The bill moves back, from June 30 to August 31, the date by which the Department of Revenue Services must report to the insurance commissioner the taxes (before allowable credits) paid by domestic insurers and HMOs during the calendar year before the previous calendar year (for example, information given in 2026 would cover 2024).

Under current law, by July 31 annually, CID gives insurers and HMOs that will be assessed a statement showing, among other things, how much was appropriated to the offices covered by the assessment (including CID, OHA, and OHS) from the Insurance Fund for that fiscal year. Under the bill, CID must instead give them the statement by September 15.

**Assessment and Payment Installments**

Under current law, the commissioner must assess insurers and HMOs, providing for any objections and adjustments, for the fiscal year

by September 1 annually. The bill pushes back this assessment date to October 1.

By law, insurers and HMOs pay the assessment in four installments, each as a certain percentage of the total amount due. Under the bill, the first payment amount (due June 30) increases from 25% to 35%, and the final payment amount (due in equal parts on December 31 and March 31) decreases from 50% to 40%. Additionally, the bill delays the second payment's due date from September 30 to October 31, but the amount remains unchanged (25%).

## **§ 6 — TERRORISM INSURANCE REQUIREMENT**

*Eliminates a requirement that condominium and unit owners' associations purchase terrorism insurance*

The bill eliminates current law's requirement that a condominium or unit owners' association's master policy include coverage for terrorism if the condominium is subject to the Common Interest Ownership Act or the Condominium Act.

In doing so, the bill allows these master policies to exclude coverage for losses caused, directly or indirectly, by terrorism (1) if the premiums charged for the policy reflect projected savings from the exclusion and (2) until the Terrorism Risk Insurance Program established under federal law expires.

### ***Background — Federal Terrorism Risk Insurance Act***

The 2002 federal Terrorism Risk Insurance Act (P.L. 107-297) created a temporary program under which the federal government shares the risk of loss from foreign terrorist attacks with the insurance industry. The 2019 Terrorism Risk Insurance Program Reauthorization Act revised several provisions of the initial act and extended the program until December 31, 2027.

EFFECTIVE DATE: Upon passage

**§§ 7 & 8 — PREMIUM BILLING NOTICES**

*Allows certain premium billing notices to be delivered electronically; requires insurers to give a (1) reasonable explanation for premium increases for personal risk policies upon written request and (2) dollar amount (or estimate) of the increase attributable to each primary factor for personal risk policies with a premium increase of at least 10%*

**Electronic Delivery and Reasonable Explanation for Certain Increases (§ 7)**

Under the bill, an insurer (or its agent) may send premium billing notices for personal or commercial risk insurance electronically if agreed to between the insurer and insured. Under current law, personal and commercial risk insurers must mail or deliver to the named insured a premium billing notice at least 30 days before the policy's renewal or anniversary date. The notice tells the insured the premium amount, length of coverage, and due date. This requirement applies to personal and commercial insurance policies that cost less than \$ 50,000 for the preceding annual policy period. It does not apply to workers' compensation insurance risks or to commercial risks subject to a premium increase of less than 10% for the upcoming policy period. Personal risk insurance includes policies covering homeowners, tenants, private passenger non-fleet automobile, and mobile manufactured home, among other things.

Additionally, for personal risk policies, the bill requires the premium billing notice to state that the insurer will give a reasonable explanation for a premium increase within 20 days after an insured asks for one in writing. Under the bill, a "reasonable explanation" is sufficient information to allow the policyholder to determine what caused the increase in terms that are understandable to an average policyholder.

The bill also requires insurers to prominently include on the first page of a premium billing notice for personal risk insurance policies, or elsewhere in a manner set by the insurance commissioner, contact information for the insured to request more information about a premium increase.

EFFECTIVE DATE: January 1, 2027

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**Dollar Amounts Attributable to Increase (§ 8)**

Under the bill, beginning July 1, 2029, when the annual premium for a personal risk insurance policy renewal increases by 10% or more, the insurer must include in the premium billing notice the dollar amount or estimated dollar amount of the increase attributable to each primary factor. If the dollar amount is estimated, the insurer must give a reasonable explanation of the estimation's degree of accuracy. However, this requirement does not apply to premium increases of \$100 or less.

The bill requires the commissioner to adopt regulations to implement this requirement. Lastly, it allows the commissioner to extend the deadline for compliance until December 1, 2029, if he determines additional time is required.

EFFECTIVE DATE: January 1, 2029

**§§ 9 & 10 — AUTOMOBILE INSURANCE**

*Makes a technical change to a provision on settlement amounts for totaled vehicles by replacing a reference to the National Automobile Dealers Association's used car guide with J.D. Power's guide to reflect J.D. Power's acquisition of NADA's used car valuation service; eliminates an annual reporting requirement for automobile insurance fraud investigations*

**Determining Settlement Amount on Totaled Vehicle (§ 9)**

By law, when an automobile insurer declares a covered, damaged vehicle a constructive total loss (the repair cost exceeds the vehicle's value), the insurer must calculate the vehicle's value to determine the settlement amount. Current law requires the insurer to use at least the average of the retail values given by two sources: (1) the National Automobile Dealers Association's (NADA) used car guide, or another publicly available automotive industry source the commissioner approves and (2) one other industry source the commissioner approves for this use.

The bill makes a technical change by substituting J.D. Power's used car guide for NADA's (J.D. Power acquired the NADA used car valuation service in 2015).

EFFECTIVE DATE: Upon passage

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**Automobile Insurance Fraud Reporting (§ 10)**

The bill eliminates a requirement under current law that insurers annually report, by each March 31, to the insurance commissioner on their automobile insurance fraud investigations and related information during the prior year. (In practice, the Insurance Department can already access the information through the National Insurance Crime Bureau.)

**§ 11 — VIATICAL SETTLEMENT REPORTING**

*Eliminates the requirement under current law that viatical settlement providers file an annual statement on settled insurance policies with the insurance commissioner*

The bill eliminates current law's requirement that viatical settlement providers file an annual statement with the insurance commissioner on specified information about settled insurance policies, such as (1) the total number and life settlement proceeds of policies settled during the immediately preceding calendar year and (2) a breakdown of the information by policy issue year. In practice, viatical settlement providers maintain this data and are legally required to give it to the insurance commissioner upon request.

The bill correspondingly eliminates the penalty of up to \$250 per day and \$25,000 in the aggregate, for failing to file an annual statement.

Viatical settlements involve the sale of a life insurance policy to a third party by a terminally ill insured person.

**§ 12 — NOTIFICATION OF FORMULARY CHANGES**

*Requires health carriers to provide at least 90 days advance notice to covered individuals and their treating physicians when removing a prescription drug from a formulary at the time of the plan's renewal*

The bill requires health carriers (insurers and HMOs) that offer health benefit plans with prescription drug coverage to notify a covered person and his or her treating physician at least 90 days before removing a prescription drug from the plan's prescription drug formulary (list of covered drugs) when the plan is renewed.

Current law generally allows health carriers to remove from a formulary, or move to a higher cost-sharing tier, any covered

prescription drug under limited conditions (for example, the U.S. Food and Drug Administration issues a statement questioning the drug's clinical safety or approves the drug for over-the-counter use). The bill specifies that health carriers may do this during the plan year.

EFFECTIVE DATE: January 1, 2027

### **§§ 13 & 14 — EXTERNAL REVIEW PROCESS DEADLINES AND NOTIFICATION**

*Requires health carriers to notify independent review organizations when their preliminary review of an external adverse determination review is complete; starts the clock for a final external review decision notice generally when the independent review organization receives the carrier's notice*

Under existing law, a covered person or their representative may ask the Insurance Department for an external review of an adverse determination (a denial of benefits by the insurer). The insurance commissioner assigns an independent review organization (IRO) to review the determination after a preliminary internal review by the health carrier to determine if the request meets certain criteria (for example, if the person was covered under the plan at the time of service).

Existing law requires the IRO to notify the commissioner, health carrier, and the covered person (and their representative if applicable) about its decision within certain time frames.

The bill makes several changes to the expedited and external review decision notice deadlines, chiefly changing when the measurement of the deadline for final notice of a decision starts from when the department assigns the review (as under current law) to when the IRO is notified (under the bill). The bill does not change the length of the review, only the start time when the review period begins.

#### ***Preliminary Review Completion Notification (§ 13)***

The bill requires the health carrier to notify the assigned IRO in writing once its preliminary review is complete. The health carrier already must notify the commissioner, the covered person, and the covered person's representative if applicable. For external reviews,

existing law requires the carrier's notification within one business day after the review is complete. For expedited external reviews, existing law requires notification on the same day the carrier completes its review.

### ***External Review***

Under the bill, for external reviews generally, the IRO must notify the parties (the commissioner, the health carrier, and the covered person and their representative) about its decision within 45 days after it receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Under current law, the IRO must notify the parties within 45 days after the commissioner assigns the review to the IRO.

### ***External Reviews of Experimental Treatment***

Under the bill, for external reviews covering experimental treatments, the IRO must notify the parties about its decision within 20 days after it receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Current law measures the 20-day deadline from time of assignment by the commissioner.

### ***Expedited External Review***

Under the bill, for expedited external reviews generally, the IRO must notify the parties as quickly as the covered person's condition requires but not later than 48 hours after the IRO receives notice that the health carrier completed the preliminary review and found the request eligible for external review. By law, the IRO has 72 hours to notify the parties if part of the IRO's work period falls on the weekend. Current law measures the 48- and 72-hour deadlines from the time of assignment by the commissioner.

### ***Expedited External Reviews of Certain Urgent Care Requests***

Under the bill, for expedited external reviews of certain urgent care requests, the IRO must notify the parties as quickly as the covered person's condition requires but not later than 24 hours after the IRO

receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Current law measures the notification deadline from the time of assignment by the commissioner. Under the bill, these urgent care requests include health care services for substance use (or a co-occurring mental disorder) or a mental disorder generally requiring inpatient services.

### ***Expedited External Reviews of Experimental Treatment***

Under the bill, for expedited external reviews covering experimental treatment, the IRO must notify the parties as quickly as the covered person's condition requires but not later than five days after the IRO receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Current law measures the notification deadline from the time of assignment by the commissioner.

### ***Notice Requirements***

By law, the IRO's decision notice must include, among other things, (1) a general description of the request, (2) the date the IRO conducted the review, (3) the date the IRO made its decision, and (4) the reason for its decision.

Current law requires the IRO's notice to also include the date the commissioner assigned the review to the IRO. The bill instead requires the IRO's notice to include the date the IRO received notice that the carrier completed its preliminary review and found it eligible for external review.

### ***Background — Related Bill***

SB 3, favorably reported by the Human Services Committee, among other things, generally shortens the time frame in which carriers must make urgent and nonurgent review request decisions.

EFFECTIVE DATE: July 1, 2026

## **§ 15 — REPORTING AGENT TERMINATIONS**

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*Requires insurers to report agent terminations for cause to the insurance commissioner within 30 days after the termination*

Current law requires insurers, upon the insurance commissioner's request, to report the facts related to an agent's termination, including the reason. If insurers terminate an agent for cause, the bill requires them to report it to the commissioner within 30 days after the termination.

## **§§ 16 & 17 — THIRD-PARTY ADMINISTRATORS**

*Requires contracts between TPAs and insurers to include a provision requiring the TPA to continue services if the insurer is insolvent or in receivership; prohibits the insurance commissioner from renewing a TPA license until the TPA pays existing law's health and welfare fee; allows insurers to conduct semi-annual reviews of TPAs remotely*

### **Contracts and License Renewals (§ 16)**

Existing law requires a TPA to have a written agreement with an insurer or other person using its services ("insurers") and sets provisions the agreement must include, such as the types of insurance the TPA may administer, a statement of activities the TPA must perform on the insurer's behalf, and termination and dispute resolution procedures. The bill requires the agreement to also include a provision requiring the TPA to continue to provide services if the insurer is insolvent or in receivership.

Additionally, if the TPA administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer must conduct a review of the TPA's operations at least semi-annually. The bill eliminates current law's requirement that at least one review be an on-site audit.

The bill also prohibits the commissioner from renewing a TPA's license unless the TPA pays the health and welfare fee required under existing law (see § 4).

### **TPA Semi-Annual Reviews (§ 17)**

By law, if a TPA administers benefits for more than 100 certificate holders (for example, insureds) on behalf of an insurer, the insurer must conduct a review of the TPA's operations at least semiannually. The bill eliminates current law's requirement that at least one review be an on-

site audit.

## **§ 18 — CASUALTY CLAIMS ADJUSTERS CONTINUING EDUCATION REQUIREMENT**

*Allows the commissioner to make regulations to establish continuing education requirements for licensed casualty claims adjusters*

The bill allows the commissioner to make regulations under the UAPA to establish continuing education requirements for licensed casualty claims adjusters.

By law, casualty claims adjusters generally investigate, negotiate, and settle losses for an insurance carrier by establishing the facts of the insured's claim during investigation. (They do not adjust claims for life, accident, health, and fire insurance.)

## **§§ 19-22 — CONNECTICUT INSURANCE GUARANTY ASSOCIATION**

*Makes changes to CIGA (which generally protects insureds in the state if certain property and casualty insurers fail) to include cybersecurity insurance policies, increase first-party real property coverage and unearned premium maximum claim amounts, and allow certain guaranty association powers and protections, among other things*

### ***Cybersecurity Insurance Coverage***

The bill expands the Connecticut Insurance Guaranty Association's (CIGA) authority to include coverage under a cybersecurity insurance policy or endorsement. "Cybersecurity insurance" is generally coverage for losses from data privacy breaches, identity theft, computer viruses, ransomware attacks, cyber extortion, unauthorized information network security intrusions, and similar issues.

Under current law, CIGA covers automobile, homeowners, workers' compensation, and other property and casualty policies. (Separately, the Connecticut Life and Health Guaranty Association covers life and health insurance policies, among other things.)

### ***Covered Claims and Insolvent Insurers***

Under CIGA, a covered claim is generally an unpaid claim under an insurance policy issued by an insurer that becomes insolvent. The bill specifies that a covered claim includes a claim under a policy that is later

made the responsibility of another insurer (it is allocated, transferred, merged, novated, or assumed) that may or may not be a CIGA member. However, these claims are covered only when:

1. the original insurer does not owe anything on the policy following a transfer;
2. the insurer who assumed the policy is found to be insolvent by a court in their jurisdiction;
3. the claim would have been covered if it had remained the original insurer's responsibility; and
4. if a member insurer transferred the policies to a non-member, that transaction received prior regulatory or judicial approval.

Generally, member insurers are (1) Connecticut-licensed insurers that issue the types of insurance CIGA covers and (2) assessed certain amounts to cover CIGA's claim obligations.

Under the bill, an insolvent insurer is an insurer that (1) was licensed in Connecticut either when the policy was issued or when the covered event occurred and (2) has received a final order of liquidation with a finding of insolvency from a court in their state. Under current law, an insolvent insurer meets the same criteria as above, but could also be the legal successor to the original insurer because of a merger or company division. Current law also states that an insolvent insurer cannot have been found to be insolvent before October 1, 1971.

### ***Maximum Claim Payments***

Generally, under current law, CIGA covers claims for most types of losses between \$100 and \$500,000 arising under policies of insurers determined to be insolvent on or after October 1, 2015 (or up to \$400,000 for insurers insolvent before October 1, 2015, and \$300,000 for insurers insolvent before October 1, 2007).

The bill removes the \$100 minimum and, for first-party real property claims for insurers insolvent after June 1, 2026, requires CIGA to pay up

to \$1,000,000 for a single occurrence under a commercial or residential policy.

The bill also caps CIGA's payment at \$500,000 for all claims under a cybersecurity insurance policy or endorsement related to a single insured event.

By law, CIGA pays covered claims for certain unearned premiums (the premium paid for a portion of a policy period for which coverage was not received). The bill sets the maximum amount of coverage at \$50,000 per policy. Under current law, the maximum is 50% of a policyholder's unearned premium, up to \$2,000 per policy.

### **Association Powers**

The bill specifies that CIGA has authority to salvage and subrogate covered claim obligations, as long as it is not named as the insolvent insurer when conferring jurisdiction. (Subrogation is the legal doctrine that allows an insurer that has paid a loss under an insurance policy to "step into the shoes of" its insured and pursue recovery from the at-fault party.) The law already deems CIGA to be the insolvent insurer, allowing it to pay covered claims and receive all the rights of the insurer as if it had not become insolvent.

Additionally, the bill specifically allows CIGA to appoint and direct (1) legal counsel retained under liability insurance policies to defend covered claims and (2) other service providers as needed.

### **Insurance Guaranty Coverage for Assumption Reinsurance (§§ 20 & 22)**

The bill provides guaranty association coverage for policyholders whose policies were assumed by an insurer not licensed in Connecticut when the policies were originally written, with insurance commissioner discretion (see §§ 23 & 24 below).

### **§§ 23 & 24 — NAIC'S ASSUMPTION REINSURANCE MODEL LAW**

*Implements the NAIC Assumption Reinsurance Model Law, including (1) notice requirements for assumption reinsurance transactions; (2) policyholder rights under*

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*assumption reinsurance agreements, including the right to reject the transfer; and (3) the insurance commissioner's discretion when an insurer is in a hazardous financial condition*

### **Assumption Reinsurance**

The bill repeals Connecticut's current assumption reinsurance law and replaces it with a National Association of Insurance Commissioners (NAIC) model law. Under the bill, an "assumption reinsurance agreement" completely transfers obligations or risks, or both, of existing in-force insurance contracts from a transferring insurer to an assuming insurer. The assuming insurer becomes directly liable to the policyholders, and the transferring insurer's insurance obligations are extinguished.

### **Conditions for Transfer**

For a transfer to take place under the bill, prior approval is required from the state insurance commissioner and generally both insurers must be licensed in Connecticut. (However, an insurer in Connecticut can assume insurance obligations and risks under a policy issued to policyholders in another state if it is licensed in the other state or that state's regulatory authority approved the assumption.)

In reviewing requests for approval, the commissioner must consider the following factors:

1. the financial condition of the transferring and assuming insurers and the transaction's effect on their financial conditions;
2. the competence, experience, and integrity of the people who control the assuming insurer;
3. the assuming party's plans or proposals for administering the policies subject to the proposed transfer;
4. whether the transfer is fair and reasonable to the policyholders of both companies;
5. whether the notice of transfer to be issued by the insurer (see below) is fair, adequate, and not misleading; and

6. anything else the commissioner deems appropriate.

Insurers domiciled in other states entering into an assumption reinsurance agreement covering Connecticut policyholders must file certain documents with the commissioner, including (1) an assumption certificate and (2) a copy of the notice of transfer and an affidavit that the transaction is subject to substantially similar requirements in the state of domicile of both the transferring and assuming insurer. If the other states do not have these requirements, then the insurer must get the Connecticut insurance commissioner's prior approval and generally comply with the bill's requirements.

Under the bill, the commissioner may approve a transfer apart from the normal requirements if the transferring insurer is in a hazardous financial condition and the transfer is deemed to be in the best interest of the policyholders.

#### ***Notice Requirement***

Under the bill, a transferring insurer must send each policyholder notice by first class mail (or personal delivery with acknowledged receipt if the business is a "home service business" for which the insurer's agent collects premiums weekly or monthly). The insurer must also send the notice to its agents or brokers of record for the affected policies.

The notice, which must be filed with the commissioner for prior approval, must include the following:

1. the proposed transfer date;
2. the name, address, and phone number of both the assuming and transferring insurer;
3. the policyholder's right to either consent to or reject the transfer and the procedure and time limit for doing so;
4. a summary of any effect that consenting to or rejecting the transfer will have on the policyholder's rights;

5. a statement that the assuming insurer is licensed in the policyholder's state or otherwise authorized to assume the business;
6. the name and address of the person at the transferring insurer to whom the policyholder should send a written statement to accept or reject the transfer;
7. the address and phone number of the insurance department in the state where the policyholder lives;
8. financial data for the transferring and assuming insurers, including ratings for the past five years, if available, and balance sheets for the past three years, among other things; and
9. an explanation of the reason for transfer.

The notice of transfer must include a pre-addressed, postage-paid response card that a policyholder may return as a written statement of transfer acceptance or rejection.

The bill authorizes the commissioner to adopt regulations to set the notice's form.

### ***Rejecting Transfer***

Under the bill, policyholders may reject transfers in writing by using the response card or other written means, but paying a premium to the assuming insurer within 24 months after receiving a notice of transfer indicates that the policyholder accepted the transfer. However, for a premium payment to constitute acceptance of a transfer, the insurer's premium billing notice must state that premium payment constitutes acceptance. The premium billing notice must also include a way for the policyholder to pay the premium while reserving the right to reject the transfer.

If the policyholder has not rejected or consented within two years after the initial notice, the transferring insurer must send the policyholder a second and final notice. If there is no policyholder

response in the month following the final notice, the policyholder is deemed to consent to the transfer.

***Current Law***

Under current law, Connecticut allows for assumption reinsurance agreements (also known as “bulk reinsurance”) that the commissioner can approve or deny, with no provision for notifying policyholders (CGS § 38a-66). Assumption reinsurance agreements become effective 20 days after they are filed with the commissioner, unless disapproved. The commissioner must deny assumption reinsurance requests before that deadline if he finds that:

1. the agreement is unfair and inequitable to any insurer or policyholder involved;
2. the agreement would reduce services to the policyholders of involved insurers;
3. the agreement lacks adequate provisions to make the reinsurer liable to the original insured for any loss or damage that occurs under the policy’s original terms;
4. the agreement does not adequately require the assuming insurer to give policyholders a certificate reflecting the assumption of liability;
5. the assuming reinsurer is not authorized to transact the type of insurance in this state;
6. the assuming reinsurer will not appoint the commissioner as its irrevocable attorney for service of process when policies or claims under the reinsurance are in force;
7. the agreement would decrease competition or create a monopoly;  
or
8. the proposed reinsurance has other reasonable objections.

The commissioner must notify the involved insurers in writing of the

reasons for the denial.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 11 Nay 2 (03/12/2026)