



General Assembly

February Session, 2026

**Raised Bill No. 5373**

LCO No. 1717



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:  
(INS)

**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 Section 38a-26 of the general statutes is repealed and the  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 and  
121 health care center shall pay such fee to the commissioner not later than  
122 February first, annually. Each such insurer, health care center, third-  
123 party administrator and exempt insurer shall pay such fee to the  
124 Insurance Commissioner not later than February first, annually.

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

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 Section 38a-48 of the general statutes is repealed and the  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

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

141 other domestic entity under chapter 207 to the Commissioner of  
142 Revenue Services prior to the application of any credits allowable or  
143 available under law to each such domestic insurance company or other  
144 domestic entity under chapter 207.

145 (b) On or before ~~July thirty-first~~ September fifteenth, annually, the  
146 Insurance Commissioner shall render to each domestic insurance  
147 company or other domestic entity liable for payment under section 38a-  
148 47:

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

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

166 (3) The proposed assessment against that company or entity,  
167 calculated in accordance with the provisions of subsection (c) of this  
168 section, provided for the purposes of this calculation the amount  
169 appropriated to the Insurance Department, the Office of the Healthcare  
170 Advocate, the Office of the Behavioral Health Advocate and the Office  
171 of Health Strategy from the Insurance Fund plus the cost of fringe

172 benefits for department and office personnel and the estimated  
173 expenditures on behalf of the department and said offices from the  
174 Capital Equipment Purchase Fund pursuant to section 4a-9, not  
175 including such expenditures made on behalf of the Health Systems  
176 Planning Unit of the Office of Health Strategy shall be deemed to be the  
177 actual expenditures of the department and said offices, and the amount  
178 appropriated to the Department of Aging and Disability Services from  
179 the Insurance Fund for the fiscal year for the fall prevention program  
180 established in section 17a-859 shall be deemed to be the actual  
181 expenditures for the program.

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

201 (2) When the amount any such company or entity is assessed  
202 pursuant to this section exceeds twenty-five per cent of the actual  
203 expenditures of the Insurance Department, the Office of the Healthcare  
204 Advocate, the Office of the Behavioral Health Advocate and the Office

205 of Health Strategy from the Insurance Fund, such excess amount shall  
206 not be paid by such company or entity but rather shall be assessed  
207 against and paid by all other such companies and entities in proportion  
208 to their respective shares of the total amount of taxes reported in the  
209 annual statement rendered to the Insurance Commissioner pursuant to  
210 subsection (a) of this section, except that for purposes of any assessment  
211 made to fund payments to the Department of Public Health to purchase  
212 vaccines, such company or entity shall be responsible for its share of the  
213 costs, notwithstanding whether its assessment exceeds twenty-five per  
214 cent of the actual expenditures of the Insurance Department, the Office  
215 of the Healthcare Advocate, the Office of the Behavioral Health  
216 Advocate and the Office of Health Strategy from the Insurance Fund.  
217 The provisions of this subdivision shall not be applicable to any  
218 corporation that has converted to a domestic mutual insurance  
219 company pursuant to section 38a-155 upon the effective date of any  
220 public act that amends said section to modify or remove any restriction  
221 on the business such a company may engage in, for purposes of any  
222 assessment due from such company on and after such effective date.

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

228 (e) On or before [~~September~~] October first, annually, for each fiscal  
229 year, the Insurance Commissioner, after receiving any objections to the  
230 proposed assessments and making such adjustments as in the  
231 commissioner's opinion may be indicated, shall assess each such  
232 domestic insurance company or other domestic entity an amount equal  
233 to its proposed assessment as so adjusted. Each domestic insurance  
234 company or other domestic entity shall pay to the Insurance  
235 Commissioner (1) on or before June thirtieth, annually, an estimated  
236 payment against its assessment for the following year equal to [~~twenty-~~  
237 ~~five~~] thirty-five per cent of its assessment for the fiscal year ending such

238 June thirtieth, (2) on or before [September thirtieth] October thirty-first,  
239 annually, twenty-five per cent of its assessment adjusted to reflect any  
240 credit or amount due from the preceding fiscal year as determined by  
241 the commissioner under subsection (f) of this section, and (3) on or  
242 before the following December thirty-first and March thirty-first,  
243 annually, each domestic insurance company or other domestic entity  
244 shall pay to the Insurance Commissioner the remaining [fifty] forty per  
245 cent of its proposed assessment to the department in two equal  
246 installments.

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

271 Commissioner the entire assessment required under this subsection in  
272 one payment when the first installment of such assessment is due.

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

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

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

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

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

302 (b) (1) A premium billing notice for any policy subject to the  
303 requirements of sections 38a-663 to 38a-696, inclusive, except a workers'  
304 compensation policy, shall be mailed or delivered to the insured by the  
305 insurer or its agent or, if agreed between the insurer and the named  
306 insured, by electronic means, not less than thirty days in advance of the  
307 policy's renewal or anniversary date, except that such notice shall not be  
308 required for a commercial risk policy if the premium for the ensuing  
309 policy period is to increase less than ten per cent on an annual basis. The  
310 premium billing notice for a personal risk insurance policy under  
311 section 38a-663 shall (A) provide a reasonable explanation for premium  
312 increases not later than twenty days after the named insured requests,  
313 in writing, information about the reasons for such premium increase, (B)  
314 be based on the rates and rules applicable to the ensuing policy period,  
315 and [shall] (C) include a notice of transfer when the policy has been  
316 transferred from an insurer to an affiliate of such insurer pursuant to the  
317 provisions of subparagraph (C) of subdivision (1) of subsection (a) of  
318 this section. As used herein, "reasonable explanation" means sufficient  
319 information, in terms that are understandable to an average  
320 policyholder, which enables the policyholder to determine the basic  
321 nature of any premium increase. The provisions of this subsection shall  
322 apply to any such policy for which the annual premium was less than  
323 fifty thousand dollars for 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 for personal risk insurance  
332 policies that includes contact information of the insurer in order that the  
333 insured may request additional information concerning the premium  
334 increase.

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

338 (NEW) (4) With respect to the renewal of any personal risk insurance  
339 policy under section 38a-663 having a premium billing increase of ten  
340 per cent or more, the premium billing notice shall provide the dollar  
341 impact or an estimate of the dollar impact of the increase attributable to  
342 each primary factor. If the premium billing notice uses estimated  
343 dollars, the insurer must provide a reasonable explanation of the degree  
344 of accuracy achieved by use of the estimated dollars. This subdivision  
345 shall not apply to premium increases of one hundred dollars or less. The  
346 Insurance Commissioner shall adopt regulations, in accordance with the  
347 provisions of chapter 54, to implement the provision of this subsection.

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

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

365 Sec. 10. Section 38a-356 of the general statutes is repealed and the

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

367 (a) Any authorized employee of the Department of Emergency  
368 Services and Public Protection, Department of Motor Vehicles or a local  
369 police department may in writing request any insurance company to  
370 release to such employee information relative to any investigation it has  
371 made concerning a motor vehicle's loss or potential loss or any  
372 information relating to fraud or potential fraud in any claim under a  
373 motor vehicle insurance policy. Any insurance company, on its own  
374 initiative, may provide and disclose information relating to fraud or  
375 potential fraud to such authorized persons. Such information shall  
376 include, but not be limited to: (1) An insurance policy relative to such  
377 loss, (2) policy premium records, (3) history of previous claims, and (4)  
378 other relevant material relating to such loss or potential loss or to such  
379 fraud or potential fraud.

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

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

395 [(d)] (c) In the absence of fraud, malice or criminal act, no insurance  
396 company, authorized employee or person who furnished information

397 on behalf of such company or department, shall be liable for damages  
398 in a civil action or subject to criminal prosecution for any oral or written  
399 statement made pursuant to the provisions of this section.

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

403 Sec. 11. Section 38a-465d of the general statutes is repealed and the  
404 following is substituted in lieu thereof (*Effective October 1, 2026*):

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

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

427 ~~[(c)]~~ (a) Except as otherwise required or permitted by law, no person,

428 including, but not limited to, a provider, broker, insurance company,  
429 insurance producer, information bureau, rating agency or company, or  
430 any other person with actual knowledge of an insured's identity, shall  
431 disclose such identity or information where there is a reasonable basis  
432 to conclude such information could be used to identify the insured or  
433 the insured's financial or medical information to any other person unless  
434 such disclosure: (1) Is necessary to effect a life settlement contract  
435 between the owner and a provider and the owner and insured have  
436 provided prior written consent to such disclosure; (2) is provided in  
437 response to an investigation or examination by the commissioner or any  
438 other governmental office or agency or pursuant to the requirements of  
439 section 38a-465i; (3) is necessary to effectuate the sale of life settlement  
440 contracts or interests therein as investments, provided the sale is  
441 conducted in accordance with applicable state and federal securities  
442 laws, and provided further the owner and the insured have both  
443 provided prior written consent to the disclosure; (4) is a term of or  
444 condition to the transfer of a policy by one provider to another provider,  
445 in which case the provider receiving such information shall comply with  
446 the confidentiality requirements specified in this subsection; (5) is  
447 necessary to allow the provider or broker or their authorized  
448 representatives to make contacts for the purpose of determining health  
449 status. For the purpose of this section, "authorized representative" does  
450 not include any person who has or may have a financial interest in the  
451 settlement contract other than a provider, licensed broker, financing  
452 entity, related provider trust or special purpose entity. Each provider or  
453 broker shall require its authorized representative to agree in writing to  
454 comply with the privacy provisions of this part; or (6) is required to  
455 purchase stop loss coverage.

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

461 confidentiality of nonpublic personal information.

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

464 (a) For the purposes of this section:

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

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

468 (3) "Health benefit plan" has the same meaning as provided in section  
469 38a-1080, except that such term shall not include a grandfathered health  
470 plan as such term is used in the Affordable Care Act;

471 (4) "Health carrier" has the same meaning as provided in section 38a-  
472 1080;

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

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

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

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

484 (2) Move a prescription drug from a cost-sharing tier that imposes a  
485 lesser coinsurance, copayment or deductible for the prescription drug to  
486 a cost-sharing tier that imposes a greater coinsurance, copayment or  
487 deductible for the prescription drug during a plan year, unless the

488 prescription drug is subject to an in-network coinsurance, copayment or  
489 deductible that is not greater than forty dollars per prescription per  
490 month in any tier.

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

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

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

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

505 (2) Move a brand-name prescription drug from a cost-sharing tier  
506 that imposes a lesser coinsurance, copayment or deductible for the  
507 brand-name prescription drug to a cost-sharing tier that imposes a  
508 greater coinsurance, copayment or deductible for the brand-name  
509 prescription drug if the health carrier adds to the drug formulary or list  
510 of covered drugs a generic prescription drug that is:

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

513 (B) In a cost-sharing tier that imposes a coinsurance, copayment or  
514 deductible for the generic prescription drug that is lesser than the  
515 coinsurance, copayment or deductible that is imposed for such brand-  
516 name prescription drug.

517 (d) A health carrier offering a health benefit plan in this state on or  
518 after January 1, 2027, that includes a pharmacy benefit and uses a drug  
519 formulary or list of covered drugs may remove a prescription drug from  
520 the drug formulary or list of covered drugs at renewal of a health benefit  
521 plan subject to at least ninety days' advance notice to a covered person  
522 and the covered person's treating physician.

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

526 [(e)] (f) (1) The Office of Health Strategy shall, at least annually,  
527 conduct a study to determine the impact that the requirements  
528 established in subsections (a) to [(d)] (e), inclusive, of this section have  
529 on the cost of health benefit plans offered, delivered, issued for delivery,  
530 renewed, amended or continued in this state and qualified health plans  
531 offered and sold through the exchange.

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

539 Sec. 13. Section 38a-591g of the general statutes is repealed and the  
540 following is substituted in lieu thereof (*Effective July 1, 2026*):

541 (a) (1) A covered person or a covered person's authorized  
542 representative may file a request for an external review or an expedited  
543 external review of an adverse determination or a final adverse  
544 determination in accordance with the provisions of this section. All  
545 requests for external review or expedited external review shall be made  
546 in writing to the commissioner. The commissioner may prescribe the  
547 form and content of such requests.

548 (2) The health carrier that issued the adverse determination or the  
549 final adverse determination that is the subject of the external review  
550 request or the expedited external review request shall pay the  
551 independent review organization for the cost of conducting the review.

552 (3) An external review decision, whether such review is a standard  
553 external review or an expedited external review, shall be binding on the  
554 health carrier or a self-insured governmental plan and the covered  
555 person, except to the extent such health carrier or covered person has  
556 other remedies available under federal or state law. A covered person  
557 or a covered person's authorized representative shall not file a  
558 subsequent request for an external review or an expedited external  
559 review that involves the same adverse determination or final adverse  
560 determination for which the covered person or the covered person's  
561 authorized representative already received an external review decision  
562 or an expedited external review decision.

563 (4) Each health carrier shall maintain written records of external  
564 reviews as set forth in section 38a-591h.

565 (5) Each independent review organization shall maintain written  
566 records as set forth in subsection (e) of section 38a-591m.

567 (b) (1) Except as otherwise provided under subdivision (2) of this  
568 subsection or subsection (d) of this section, a covered person or a  
569 covered person's authorized representative shall not file a request for an  
570 external review or an expedited external review until the covered  
571 person or the covered person's authorized representative has exhausted  
572 the health carrier's internal grievance process.

573 (2) A health carrier may waive its internal grievance process and the  
574 requirement for a covered person to exhaust such process prior to filing  
575 a request for an external review or an expedited external review.

576 (c) (1) At the same time a health carrier sends to a covered person or  
577 a covered person's authorized representative a written notice of an

578 adverse determination or a final adverse determination issued by the  
579 health carrier, the health carrier shall include a written disclosure to the  
580 covered person and, if applicable, the covered person's authorized  
581 representative of the covered person's right to request an external  
582 review.

583 (2) The written notice shall include:

584 (A) The following statement or a statement in substantially similar  
585 language: "We have denied your request for benefit approval for a  
586 health care service or course of treatment. You may have the right to  
587 have our decision reviewed by health care professionals who have no  
588 association with us by submitting a request for external review to the  
589 office of the Insurance Commissioner, if our decision involved making  
590 a judgment as to the medical necessity, appropriateness, health care  
591 setting, level of care or effectiveness of the health care service or  
592 treatment you requested.";

593 (B) For a notice related to an adverse determination, a statement  
594 informing the covered person that:

595 (i) If the covered person has a medical condition for which the time  
596 period for completion of an expedited internal review of a grievance  
597 involving an adverse determination would seriously jeopardize the life  
598 or health of the covered person or would jeopardize the covered  
599 person's ability to regain maximum function, the covered person or the  
600 covered person's authorized representative may (I) file a request for an  
601 expedited external review, or (II) file a request for an expedited external  
602 review if the adverse determination involves a denial of coverage based  
603 on a determination that the recommended or requested health care  
604 service or treatment is experimental or investigational and the covered  
605 person's treating health care professional certifies in writing that such  
606 recommended or requested health care service or treatment would be  
607 significantly less effective if not promptly initiated; and

608 (ii) Such request for expedited external review may be filed at the

609 same time the covered person or the covered person's authorized  
610 representative files a request for an expedited internal review of a  
611 grievance involving an adverse determination, except that the  
612 independent review organization assigned to conduct the expedited  
613 external review shall determine whether the covered person shall be  
614 required to complete the expedited internal review of the grievance  
615 prior to conducting the expedited external review;

616 (C) For a notice related to a final adverse determination, a statement  
617 informing the covered person that:

618 (i) If the covered person has a medical condition for which the time  
619 period for completion of an external review would seriously jeopardize  
620 the life or health of the covered person or would jeopardize the covered  
621 person's ability to regain maximum function, the covered person or the  
622 covered person's authorized representative may file a request for an  
623 expedited external review; or

624 (ii) If the final adverse determination concerns (I) an admission,  
625 availability of care, continued stay or health care service for which the  
626 covered person received emergency services but has not been  
627 discharged from a facility, the covered person or the covered person's  
628 authorized representative may file a request for an expedited external  
629 review, or (II) a denial of coverage based on a determination that the  
630 recommended or requested health care service or treatment is  
631 experimental or investigational and the covered person's treating health  
632 care professional certifies in writing that such recommended or  
633 requested health care service or treatment would be significantly less  
634 effective if not promptly initiated, the covered person or the covered  
635 person's authorized representative may file a request for an expedited  
636 external review;

637 (D) (i) A copy of the description of both the standard and expedited  
638 external review procedures the health carrier is required to provide,  
639 highlighting the provisions in the external review procedures that give

640 the covered person or the covered person's authorized representative  
641 the opportunity to submit additional information and including any  
642 forms used to process an external review or an expedited external  
643 review;

644 (ii) As part of any forms provided under subparagraph (D)(i) of this  
645 subdivision, an authorization form or other document approved by the  
646 commissioner that complies with the requirements of 45 CFR 164.508,  
647 as amended from time to time, by which the covered person shall  
648 authorize the health carrier and the covered person's treating health care  
649 professional to release, transfer or otherwise divulge, in accordance with  
650 sections 38a-975 to 38a-999a, inclusive, the covered person's protected  
651 health information including medical records for purposes of  
652 conducting an external review or an expedited external review;

653 (E) A statement that the covered person or the covered person's  
654 authorized representative may request, free of charge, copies of all  
655 documents, communications, information and evidence regarding the  
656 adverse determination or the final adverse determination that were not  
657 previously provided to the covered person or the covered person's  
658 authorized representative.

659 (3) Upon request pursuant to subparagraph (E) of subdivision (2) of  
660 this subsection, the health carrier shall provide such copies in  
661 accordance with subsection (b) of section 38a-591n.

662 (d) (1) A covered person or a covered person's authorized  
663 representative may file a request for an expedited external review of an  
664 adverse determination or a final adverse determination with the  
665 commissioner, except that an expedited external review shall not be  
666 provided for a retrospective review request of an adverse determination  
667 or a final adverse determination.

668 (2) Such request may be filed at the time the covered person receives:

669 (A) An adverse determination, if:

670 (i) (I) The covered person has a medical condition for which the time  
671 period for completion of an expedited internal review of the adverse  
672 determination would seriously jeopardize the life or health of the  
673 covered person or would jeopardize the covered person's ability to  
674 regain maximum function; or

675 (II) The denial of coverage is based on a determination that the  
676 recommended or requested health care service or treatment is  
677 experimental or investigational and the covered person's treating health  
678 care professional certifies in writing that such recommended or  
679 requested health care service or treatment would be significantly less  
680 effective if not promptly initiated; and

681 (ii) The covered person or the covered person's authorized  
682 representative has filed a request for an expedited internal review of the  
683 adverse determination; or

684 (B) A final adverse determination if:

685 (i) The covered person has a medical condition where the time period  
686 for completion of a standard external review would seriously jeopardize  
687 the life or health of the covered person or would jeopardize the covered  
688 person's ability to regain maximum function;

689 (ii) The final adverse determination concerns an admission,  
690 availability of care, continued stay or health care service for which the  
691 covered person received emergency services but has not been  
692 discharged from a facility; or

693 (iii) The denial of coverage is based on a determination that the  
694 recommended or requested health care service or treatment is  
695 experimental or investigational and the covered person's treating health  
696 care professional certifies in writing that such recommended or  
697 requested health care service or treatment would be significantly less  
698 effective if not promptly initiated.

699 (3) Such covered person or covered person's authorized  
700 representative shall not be required to file a request for an external  
701 review prior to, or at the same time as, the filing of a request for an  
702 expedited external review and shall not be precluded from filing a  
703 request for an external review, within the time periods set forth in  
704 subsection (e) of this section, if the request for an expedited external  
705 review is determined to be ineligible for such review.

706 (e) (1) Not later than one hundred twenty calendar days after a  
707 covered person or a covered person's authorized representative receives  
708 a notice of an adverse determination or a final adverse determination,  
709 the covered person or the covered person's authorized representative  
710 may file a request for an external review or an expedited external review  
711 with the commissioner in accordance with this section.

712 (2) Not later than one business day after the commissioner receives a  
713 request that is complete, the commissioner shall:

714 (i) Send a copy of such request to the health carrier that issued the  
715 adverse determination or the final adverse determination that is the  
716 subject of the request; and

717 (ii) Assign an independent review organization from the list of  
718 approved independent review organizations compiled and maintained  
719 by the commissioner pursuant to section 38a-591l to conduct the review  
720 and notify the health carrier of the name of the assigned independent  
721 review organization. Such assignment shall be done on a random basis  
722 among those approved independent review organizations qualified to  
723 conduct the particular review based on the nature of the health care  
724 service that is the subject of the adverse determination or the final  
725 adverse determination and other circumstances, including conflict of  
726 interest concerns as set forth in section 38a-591m.

727 (3) Not later than five business days after the health carrier receives  
728 the copy of an external review request or one calendar day after the  
729 health carrier receives the copy of an expedited external review request,

730 from the commissioner, the health carrier shall complete a preliminary  
731 review of the request to determine whether:

732 (A) The individual is or was a covered person under the health  
733 benefit plan at the time the health care service was requested or, in the  
734 case of an external review of a retrospective review request, was a  
735 covered person in the health benefit plan at the time the health care  
736 service was provided;

737 (B) The health care service that is the subject of the adverse  
738 determination or the final adverse determination is a covered service  
739 under the covered person's health benefit plan but for the health  
740 carrier's determination that the health care service is not covered  
741 because the health care service does not meet the health carrier's  
742 requirements for medical necessity, appropriateness, health care setting,  
743 level of care or effectiveness;

744 (C) If the health care service or treatment is experimental or  
745 investigational:

746 (i) Is a covered benefit under the covered person's health benefit plan  
747 but for the health carrier's determination that the service or treatment is  
748 experimental or investigational for a particular medical condition;

749 (ii) Is not explicitly listed as an excluded benefit under the covered  
750 person's health benefit plan;

751 (iii) The covered person's treating health care professional has  
752 certified that one of the following situations is applicable:

753 (I) Standard health care services or treatments have not been effective  
754 in improving the medical condition of the covered person;

755 (II) Standard health care services or treatments are not medically  
756 appropriate for the covered person; or

757 (III) There is no available standard health care service or treatment

758 covered by the health carrier that is more beneficial than the  
759 recommended or requested health care service or treatment; and

760 (iv) The covered person's treating health care professional:

761 (I) Has recommended a health care service or treatment that the  
762 health care professional certifies, in writing, is likely to be more  
763 beneficial to the covered person, in the health care professional's  
764 opinion, than any available standard health care services or treatments;  
765 or

766 (II) Is a licensed, board certified or board eligible health care  
767 professional qualified to practice in the area of medicine appropriate to  
768 treat the covered person's condition and has certified in writing that  
769 scientifically valid studies using accepted protocols demonstrate that  
770 the health care service or treatment requested by the covered person that  
771 is the subject of the adverse determination or the final adverse  
772 determination is likely to be more beneficial to the covered person than  
773 any available standard health care services or treatments;

774 (D) The covered person has exhausted the health carrier's internal  
775 grievance process or the covered person or the covered person's  
776 authorized representative has filed a request for an expedited external  
777 review as provided under subsection (d) of this section; and

778 (E) The covered person has provided all the information and forms  
779 required to process an external review or an expedited external review,  
780 including an authorization form as set forth in subparagraph (D)(ii) of  
781 subdivision (2) of subsection (c) of this section.

782 (4) (A) Not later than one business day after the preliminary review  
783 of an external review request or the day the preliminary review of an  
784 expedited external review request is completed, the health carrier shall  
785 notify the commissioner, the assigned independent review  
786 organization, the covered person and, if applicable, the covered person's  
787 authorized representative in writing whether the request for an external

788 review or an expedited external review is complete and eligible for such  
789 review. The commissioner may specify the form for the health carrier's  
790 notice of initial determination under this subdivision and any  
791 supporting information required to be included in the notice.

792 (B) If the external review or the expedited external review is accepted,  
793 the health carrier shall notify the commissioner, the covered person and,  
794 if applicable, the covered person's authorized representative in writing  
795 of the request's eligibility and acceptance for external review or  
796 expedited external review. For an external review, the health carrier  
797 shall include in such notice (i) a statement that the covered person or the  
798 covered person's authorized representative may submit, not later than  
799 five business days after the covered person or the covered person's  
800 authorized representative, as applicable, received such notice,  
801 additional information in writing to the assigned independent review  
802 organization that such organization shall consider when conducting the  
803 external review, and (ii) where and how such additional information is  
804 to be submitted. If additional information is submitted later than five  
805 business days after the covered person or the covered person's  
806 authorized representative, as applicable, received such notice, the  
807 independent review organization may, but shall not be required to,  
808 accept and consider such additional information.

809 (C) If the request:

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

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

818 (D) The notice of initial determination shall include a statement

819 informing the covered person and, if applicable, the covered person's  
820 authorized representative that a health carrier's initial determination  
821 that the request for an external review or an expedited external review  
822 is ineligible for review may be appealed to the commissioner.

823 (E) Notwithstanding a health carrier's initial determination that a  
824 request for an external review or an expedited external review is  
825 ineligible for review, the commissioner may determine, pursuant to the  
826 terms of the covered person's health benefit plan, that such request is  
827 eligible for such review and assign an independent review organization  
828 to conduct such review. Any such review shall be conducted in  
829 accordance with this section.

830 (f) (1) Not later than five business days for an external review or one  
831 calendar day for an expedited external review, after the health carrier  
832 accepts the external review or expedited external review, the health  
833 carrier or its designee utilization review company shall provide to the  
834 assigned independent review organization the documents and any  
835 information such health carrier or utilization review company  
836 considered in making the adverse determination or the final adverse  
837 determination.

838 (2) The failure of the health carrier or its designee utilization review  
839 company to provide the documents and information within the time  
840 specified in subdivision (1) of this subsection shall not delay the  
841 conducting of the review.

842 (3) (A) If the health carrier or its designee utilization review company  
843 fails to provide the documents and information within the time period  
844 specified in subdivision (1) of this subsection, the independent review  
845 organization may terminate the review and make a decision to reverse  
846 the adverse determination or the final adverse determination.

847 (B) Not later than one business day after terminating the review and  
848 making the decision to reverse the adverse determination or the final  
849 adverse determination, the independent review organization shall

850 notify the commissioner, the health carrier, the covered person and, if  
851 applicable, the covered person's authorized representative in writing of  
852 such decision.

853 (g) (1) The assigned independent review organization shall review all  
854 the information and documents received pursuant to subsection (f) of  
855 this section. In reaching a decision, the independent review organization  
856 shall not be bound by any decisions or conclusions reached during the  
857 health carrier's utilization review process.

858 (2) Not later than one business day after receiving any information  
859 submitted by the covered person or the covered person's authorized  
860 representative pursuant to subparagraph (B) of subdivision (4) of  
861 subsection (e) of this section, the independent review organization shall  
862 forward such information to the health carrier.

863 (3) (A) Upon the receipt of any information forwarded pursuant to  
864 subdivision (2) of this subsection, the health carrier may reconsider its  
865 adverse determination or the final adverse determination that is the  
866 subject of the review. Such reconsideration shall not delay or terminate  
867 the review.

868 (B) The independent review organization shall terminate the review  
869 if the health carrier decides, upon completion of its reconsideration and  
870 notice to such organization as provided in subparagraph (C) of this  
871 subdivision, to reverse its adverse determination or its final adverse  
872 determination and provide coverage or payment for the health care  
873 service or treatment that is the subject of the adverse determination or  
874 the final adverse determination.

875 (C) Not later than one business day after making the decision to  
876 reverse its adverse determination or its final adverse determination, the  
877 health carrier shall notify the commissioner, the assigned independent  
878 review organization, the covered person and, if applicable, the covered  
879 person's authorized representative in writing of such decision.

880 (h) In addition to the documents and information received pursuant  
881 to subsection (f) of this section, the independent review organization  
882 shall consider, to the extent the documents or information are available  
883 and the independent review organization considers them appropriate,  
884 the following in reaching a decision:

885 (1) The covered person's medical records;

886 (2) The attending health care professional's recommendation;

887 (3) Consulting reports from appropriate health care professionals and  
888 other documents submitted by the health carrier, the covered person,  
889 the covered person's authorized representative or the covered person's  
890 treating health care professional;

891 (4) The terms of coverage under the covered person's health benefit  
892 plan to ensure that the independent review organization's decision is  
893 not contrary to the terms of coverage under such health benefit plan;

894 (5) The most appropriate practice guidelines, which shall include  
895 applicable evidence-based standards and may include any other  
896 practice guidelines developed by the federal government, national or  
897 professional medical societies, medical boards or medical associations;

898 (6) Any applicable clinical review criteria developed and used by the  
899 health carrier or its designee utilization review company; and

900 (7) The opinion or opinions of the independent review organization's  
901 clinical peer or peers who conducted the review after considering  
902 subdivisions (1) to (6), inclusive, of this subsection.

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

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

913 (B) For external reviews involving a determination that the  
914 recommended or requested health care service or treatment is  
915 experimental or investigational, twenty calendar days after such  
916 organization receives [the assignment from the commissioner to  
917 conduct such review] notice that the health carrier has completed a  
918 preliminary review of the request and determined that the review is  
919 complete and eligible for review;

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

929 (D) For expedited external reviews involving a health care service or  
930 course of treatment specified under subparagraph (B) or (C) of  
931 subdivision (38) of section 38a-591a, as expeditiously as the covered  
932 person's medical condition requires, but not later than twenty-four  
933 hours after such organization receives [the assignment from the  
934 commissioner to conduct such review] notice that the health carrier has  
935 completed a preliminary review of the request and determined that the  
936 review is complete and eligible for review; and

937 (E) For expedited external reviews involving a determination that the  
938 recommended or requested health care service or treatment is

939 experimental or investigational, as expeditiously as the covered person's  
940 medical condition requires, but not later than five calendar days after  
941 such organization receives [the assignment from the commissioner to  
942 conduct such review] notice that the health carrier has completed a  
943 preliminary review of the request and determined that the review is  
944 complete and eligible for review.

945 (2) Such notice shall include:

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

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

951 (C) The date the review was conducted;

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

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

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

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

960 (H) For a review involving a determination that the recommended or  
961 requested health care service or treatment is experimental or  
962 investigational:

963 (i) A description of the covered person's medical condition;

964 (ii) A description of the indicators relevant to determining whether  
965 there is sufficient evidence to demonstrate that (I) the recommended or

966 requested health care service or treatment is likely to be more beneficial  
967 to the covered person than any available standard health care services  
968 or treatments, and (II) the adverse risks of the recommended or  
969 requested health care service or treatment would not be substantially  
970 increased over those of available standard health care services or  
971 treatments;

972 (iii) A description and analysis of any medical or scientific evidence  
973 considered in reaching the opinion;

974 (iv) A description and analysis of any evidence-based standard; and

975 (v) Information on whether the clinical peer's rationale for the  
976 opinion is based on the documents and information set forth in  
977 subsection (f) of this section.

978 (3) Upon the receipt of a notice of the independent review  
979 organization's decision to reverse or revise an adverse determination or  
980 a final adverse determination, the health carrier shall immediately  
981 approve the coverage that was the subject of the adverse determination  
982 or the final adverse determination.

983 Sec. 14. Section 38a-708 of the general statutes is repealed and the  
984 following is substituted in lieu thereof (*Effective October 1, 2026*):

985 Upon the request of the Insurance Commissioner, any insurance  
986 company shall furnish to the Insurance Department the facts relative to  
987 the termination of an agent's appointment and the causes thereof. If a  
988 company terminates an agent's appointment for cause, such termination  
989 shall be reported to the commissioner not later than thirty calendar days  
990 after such termination. No agent shall have a cause of action against any  
991 insurance company as a result of such company's having furnished to  
992 said department pursuant to this section any statement, oral or written,  
993 unless such statement is false and was known by such company to be  
994 false when made.

995 Sec. 15. Section 38a-720a of the general statutes is repealed and the  
996 following is substituted in lieu thereof (*Effective October 1, 2026*):

997 (a) No person shall offer to act as or hold himself out to be a third-  
998 party administrator in this state unless such person is licensed pursuant  
999 to section 38a-720j, or is exempt from licensure pursuant to subsection  
1000 (b) of this section. This requirement shall not apply to a person  
1001 employed by a third-party administrator to the extent that such person's  
1002 activities are under the supervision and control of the third-party  
1003 administrator. The authority granted to a third-party administrator  
1004 pursuant to sections 38a-720 to 38a-720i, inclusive, shall not exempt such  
1005 third-party administrator's employees from the licensing requirements  
1006 of chapters 701b and 702.

1007 (b) (1) Any insurer licensed in this state that directly or indirectly  
1008 underwrites, collects premiums or charges from, or adjusts or settles  
1009 claims for other than its policyholders, subscribers and certificate  
1010 holders shall be exempt from sections 38a-720 to 38a-720n, inclusive,  
1011 provided such activities only involve the lines of insurance for which  
1012 such insurer is licensed in this state. Any such insurer shall (A) be  
1013 subject to the provisions of chapter 704, (B) respond to all complaint  
1014 inquiries received from the Insurance Department, not later than ten  
1015 calendar days after the date a complaint is received by the insurer, and  
1016 (C) with respect to any advertising that mentions any customer, obtain  
1017 such customer's prior written consent.

1018 (2) Nothing in this section shall authorize the commissioner to  
1019 regulate a self-insured health plan subject to the Employee Retirement  
1020 Income Security Act of 1974. The commissioner is authorized to regulate  
1021 those activities an insurer undertakes for the administration of a self-  
1022 insured health plan that do not relate to the health benefit plan and that  
1023 comport with the commissioner's statutory authority to regulate  
1024 insurance and the business of insurance as provided for in 29 USC 1144,  
1025 as amended from time to time.

1026 (c) No third-party administrator shall act as such without a written  
1027 agreement between such third-party administrator and an insurer or  
1028 other person utilizing the services of the third-party administrator,  
1029 which shall be retained as part of the official records of both the third-  
1030 party administrator and such insurer or other person for the duration of  
1031 such agreement and for five years thereafter. The agreement shall  
1032 contain all provisions required by this section, except insofar as those  
1033 provisions that do not apply to the activities performed by the third-  
1034 party administrator.

1035 (d) The written agreement set forth in subsection (c) of this section  
1036 shall include, but not be limited to:

1037 (1) A statement of activities that the third-party administrator shall  
1038 undertake on behalf of the insurer or other person utilizing the services  
1039 of the third-party administrator, and the lines, classes or types of  
1040 insurance such third-party administrator is authorized to administer;

1041 (2) A statement of the activities and responsibilities of the third-party  
1042 administrator regarding the administration of or any standards  
1043 pertaining to business underwritten by the insurer, benefits, premium  
1044 rates, underwriting criteria or claims payment;

1045 (3) A provision requiring the third-party administrator to render an  
1046 accounting, on such frequency as the parties agree, that details all  
1047 transactions performed by the third-party administrator pertaining to  
1048 the business underwritten by the insurer or the business of the person  
1049 utilizing the services of the third-party administrator;

1050 (4) The procedures for any withdrawals to be made by the third-party  
1051 administrator from the fiduciary account established under section 38a-  
1052 720f. Such procedures shall address, but not be limited to: (A)  
1053 Remittance to an insurer or other person utilizing the services of the  
1054 third-party administrator who is entitled to remittance, (B) deposit in an  
1055 account maintained in the name of the insurer or other person utilizing  
1056 the services of the third-party administrator, (C) transfer to and deposit

1057 in a claims-paying account, with claims to be paid as provided for in  
1058 subsection (d) of section 38a-720f, (D) payment to a group policyholder  
1059 for remittance to the insurer or other person utilizing the services of the  
1060 third-party administrator entitled to such remittance, (E) payment to the  
1061 third-party administrator for its commissions, fees or charges, and (F)  
1062 remittance of return premiums to the person or persons entitled to such  
1063 return premiums;

1064 (5) Procedures and requirements for the disclosures required to be  
1065 made by the third-party administrator under section 38a-720h; [and]

1066 (6) A termination provision, by which either party to the written  
1067 agreement may terminate such agreement for cause, that includes a  
1068 procedure to resolve any disputes regarding the cause for termination  
1069 of such agreement; and

1070 (7) A provision requiring the third-party administrator to continue to  
1071 provide the services contemplated under the agreement in the event of  
1072 the insolvency or receivership of the insurer.

1073 (e) A third-party administrator or insurer or other person utilizing  
1074 the services of the third-party administrator may, with written notice,  
1075 terminate the written agreement for cause as provided in such written  
1076 agreement. The insurer may suspend the underwriting authority of the  
1077 third-party administrator during the pendency of any dispute regarding  
1078 the cause for termination of the written agreement. The insurer or other  
1079 person utilizing the services of the third-party administrator shall fulfill  
1080 any legal obligations with respect to policies or plans affected by the  
1081 written agreement, regardless of any dispute between the third-party  
1082 administrator and the insurer or other person utilizing the services of  
1083 the third-party administrator.

1084 (f) No license issued to a third-party administrator shall be renewed  
1085 unless the third-party administrator has complied with the  
1086 requirements of section 19a-7j, as amended by this act.

1087 Sec. 16. Section 38a-720e of the general statutes is repealed and the  
1088 following is substituted in lieu thereof (*Effective October 1, 2026*):

1089 (a) Each insurer or other person utilizing the services of a third-party  
1090 administrator shall be responsible for determining the benefits,  
1091 premium rates, underwriting criteria and claims payment procedures  
1092 for the lines, classes or types of insurance such third-party administrator  
1093 is authorized to administer, and for securing reinsurance, if any. The  
1094 insurer or other person utilizing the services of a third-party  
1095 administrator shall provide to such third-party administrator, in  
1096 writing, procedures pertaining to such third-party administrator's  
1097 administration of benefits, premium rates, underwriting criteria and  
1098 claims payment. Each insurer or other person utilizing the services of a  
1099 third-party administrator shall be responsible for the competent  
1100 administration of such insurer's or other person's benefit and service  
1101 programs.

1102 (b) If a third-party administrator administers benefits for more than  
1103 one hundred certificate holders on behalf of an insurer or other person  
1104 utilizing the services of a third-party administrator, such insurer or  
1105 other person shall, at least semiannually, conduct a review of the  
1106 operations of the third-party administrator. [At least one such review  
1107 shall be an on-site audit of the operations of the third-party  
1108 administrator.]

1109 Sec. 17. Subsection (b) of section 38a-792 of the 2026 supplement to  
1110 the general statutes is repealed and the following is substituted in lieu  
1111 thereof (*Effective October 1, 2026*):

1112 (b) The commissioner may prescribe reasonable regulations, in  
1113 accordance with the provisions of chapter 54, governing the licensing of  
1114 casualty claims adjusters, [and] the adjustment of casualty claims and  
1115 the establishment of continuing education requirements for persons  
1116 licensed as casualty claims adjusters.

1117 Sec. 18. Section 38a-837 of the general statutes is repealed and the

1118 following is substituted in lieu thereof (*Effective October 1, 2026*):

1119 Sections 38a-836 to 38a-853, inclusive, shall apply to all kinds of direct  
1120 insurance, [except] but shall not be applicable to the following:

1121 (1) Life, annuity, health or disability insurance;

1122 (2) Mortgage guaranty, financial guaranty or other forms of insurance  
1123 offering protection against investment risks;

1124 (3) Fidelity or surety or any bonding obligations;

1125 (4) Credit insurance, vendors' single interest insurance, or collateral  
1126 protection insurance or any similar insurance protecting the interests of  
1127 a creditor arising out of a creditor-debtor transaction;

1128 (5) [Insurance] Except for coverages that may be set forth in a  
1129 cybersecurity policy, insurance of warranties or service contracts,  
1130 including insurance that provides for the repair, replacement or service  
1131 of goods or property, or indemnification for repair, replacement or  
1132 service, for the operational or structural failure of the goods or property  
1133 due to a defect in materials, workmanship or normal wear and tear, or  
1134 that provides reimbursement for the liability incurred by the issuer of  
1135 agreements or service contracts that provide such benefits;

1136 (6) Title insurance;

1137 (7) Ocean marine insurance;

1138 (8) Any transaction or combination of transactions between a person,  
1139 including affiliates of such person, and an insurer, including affiliates of  
1140 such insurer, which involves the transfer of investment or credit risk  
1141 unaccompanied by transfer of insurance risk;

1142 (9) Any insurance provided by or guaranteed by government; or

1143 (10) Flood insurance pursuant to the federal Flood Disaster Protection  
1144 Act of 1973, as amended, 42 USC Section 4001, et seq.

1145 Sec. 19. Section 38a-838 of the general statutes is repealed and the  
1146 following is substituted in lieu thereof (*Effective October 1, 2026*):

1147 The following terms as used in sections 38a-836 to 38a-853, inclusive,  
1148 unless the context otherwise requires or a different meaning is  
1149 specifically prescribed, shall have the following meanings:

1150 (1) "Account" means any one of the three accounts created by section  
1151 38a-839;

1152 (2) "Affiliate" means any affiliate, as defined in section 38a-1, of an  
1153 insolvent insurer;

1154 (3) "Association" means the Connecticut Insurance Guaranty  
1155 Association created under section 38a-839;

1156 (4) "Commissioner" means the Insurance Commissioner;

1157 (5) (A) "Covered claim" means an unpaid claim, including, but not  
1158 limited to, one for unearned premiums, that arises out of and is within  
1159 the coverage and subject to the applicable limits of an insurance policy  
1160 to which sections 38a-836 to 38a-853, inclusive, apply, if such insurer  
1161 becomes an insolvent insurer or such claim was assumed as a direct  
1162 obligation by an insurer that becomes an insolvent insurer, [where such  
1163 obligation was assumed through a merger or an acquisition, pursuant  
1164 to an acquisition of assets and assumption of liabilities or pursuant to  
1165 an assumption reinsurance transaction,] and (i) the claimant or insured  
1166 is a resident of this state at the time of the insured event, or (ii) the claim  
1167 is a first party claim for damage to property with a permanent location  
1168 in this state. For the purposes of this subparagraph, the residence of a  
1169 claimant or an insured that is not an individual shall be the state in  
1170 which such claimant's or insured's principal place of business is located  
1171 at the time of the insured event. "Covered claim" includes claim  
1172 obligations arising from the issuance of an insurance policy by a  
1173 member insurer, which are later allocated, transferred, merged into,  
1174 novated, assumed by or otherwise made the sole responsibility of

1175 another member or nonmember insurer if all the following conditions  
1176 are satisfied: (I) The original member insurer has no remaining  
1177 obligations on the policy after the transfer; (II) a final order of  
1178 liquidation with a finding of insolvency has been entered against the  
1179 insurer that assumed the member insurer's coverage obligations by a  
1180 court of competent jurisdiction in the insurer's state of domicile; (III) the  
1181 claim would have been a covered claim, as defined in the first sentence  
1182 of this subparagraph, if the claim had remained the responsibility of the  
1183 original member insurer and the order of liquidation had been entered  
1184 against the original member insurer, with the same claim submission  
1185 date and liquidation date; and (IV) in cases where the member insurer's  
1186 coverage obligations were assumed by a nonmember insurer, the  
1187 transaction received prior regulatory or judicial approval.

1188 (B) "Covered claim" does not include (i) any claim by or for the benefit  
1189 of any reinsurer, insurer, insurance pool or underwriting association, as  
1190 subrogation recoveries or otherwise, provided a claim for any such  
1191 amount, asserted against a person insured under a policy issued by an  
1192 insurer that has become an insolvent insurer, that, if it were not a claim  
1193 by or for the benefit of a reinsurer, insurer, insurance pool or  
1194 underwriting association, would be a "covered claim", may be filed  
1195 directly with the receiver of the insolvent insurer but in no event shall  
1196 any such claim be asserted against the insured of such insolvent insurer,  
1197 (ii) any claim by or on behalf of an individual who is neither a citizen of  
1198 the United States nor an alien legally resident in the United States at the  
1199 time of the insured event, or an entity other than an individual whose  
1200 principal place of business is not in the United States at the time of the  
1201 insured event, and it arises out of an accident, occurrence, offense, act,  
1202 error or omission that takes place outside of the United States, or a loss  
1203 to property normally located outside of the United States or, if a  
1204 workers' compensation claim, it arises out of employment outside of the  
1205 United States, (iii) any claim by or on behalf of a person who is not a  
1206 resident of this state, other than a claim for compensation or any other  
1207 benefit that arises out of and is within the coverage of a workers'

1208 compensation policy, against an insured whose net worth at the time  
1209 the policy was issued or at any time thereafter exceeded twenty-five  
1210 million dollars, provided an insured's net worth for purposes of this  
1211 section and section 38a-844 shall be deemed to include the aggregate net  
1212 worth of the insured and all of its subsidiaries as calculated on a  
1213 consolidated basis, (iv) any claim by or on behalf of an affiliate of the  
1214 insolvent insurer at the time the policy was issued or at the time of the  
1215 insured event, (v) any claim arising out of a policy issued by an insurer  
1216 that was not licensed to transact insurance in this state at the time the  
1217 policy was issued, when it assumed the obligation for the covered claim  
1218 or when the insured event occurred, unless the assumption of the  
1219 obligation was effected pursuant to subsection (g) of section 22 of this  
1220 act, (vi) any amount due under any policy originally issued by a surplus  
1221 lines carrier, risk retention group, self-insurer or group self-insurer, (vii)  
1222 any obligation assumed by an insolvent insurer after the  
1223 commencement of any delinquency proceeding, as defined in section  
1224 38a-905, involving the insolvent insurer or the original insurer, unless it  
1225 would have been a covered claim absent such assumption, or (viii) any  
1226 obligation assumed by an insolvent insurer in a transaction in which the  
1227 original insurer remains separately liable;

1228 (6) "Cybersecurity insurance", for purposes of sections 38a-836 to 38a-  
1229 853, inclusive, includes first and third-party coverage, in a policy or  
1230 endorsement, written on a direct, admitted basis for losses and loss  
1231 mitigation arising out of or relating to data privacy breaches,  
1232 unauthorized information network security intrusions, computer  
1233 viruses, ransomware, cyber extortion, identity theft and similar  
1234 exposures;

1235 ~~[(6)]~~ ~~(7)~~ "Insolvent insurer" means an insurer (A) ~~[(i)]~~ licensed to  
1236 transact insurance in this state at the time the policy was issued, ~~[when~~  
1237 ~~it assumed the obligation for the covered claim]~~ or when the insured  
1238 event occurred, and ~~[(ii)]~~ ~~(B)~~ against which a final order of liquidation  
1239 with a finding of insolvency has been entered by a court of competent  
1240 jurisdiction in the insurer's state of domicile; ~~[(B) that is (i) the legal~~

1241 successor of an insurer that was licensed to transact insurance in this  
1242 state either at the time the policy was issued or when the insured event  
1243 occurred, by reason of a merger, provided such merger is approved by  
1244 an insurance regulator having jurisdiction over such merger, and (ii)  
1245 against which a final order of liquidation with a finding of insolvency  
1246 has been entered by a court of competent jurisdiction in the insurer's  
1247 state of domicile; or (C) that (i) succeeds to the policy obligations of an  
1248 insurer that was licensed to transact insurance in this state either at the  
1249 time the policy was issued or when the insured event occurred, by  
1250 reason of a division whereby policies issued by such licensed insurer are  
1251 allocated to or otherwise become the obligation of a successor insurer,  
1252 provided such division is approved (I) in a jurisdiction that allows such  
1253 division, and (II) by an insurance regulator having jurisdiction over such  
1254 division, and (ii) against which a final order of liquidation with a finding  
1255 of insolvency has been entered by a court of competent jurisdiction in  
1256 the succeeding insurer's state of domicile. "Insolvent insurer" shall not  
1257 be construed to mean any insurer with respect to which an order, decree,  
1258 judgment or finding of insolvency, whether permanent or temporary in  
1259 nature, or order of rehabilitation or conservation has been issued by a  
1260 court of competent jurisdiction prior to October 1, 1971;]

1261 [(7)] (8) "Member insurer" means any person who (A) writes any kind  
1262 of insurance to which sections 38a-836 to 38a-853, inclusive, apply under  
1263 section 38a-837, as amended by this act, including, but not limited to,  
1264 the exchange of reciprocal or interinsurance contracts, and (B) is  
1265 licensed to transact insurance in this state. An insurer shall cease to be a  
1266 member insurer effective on the day following the termination or  
1267 expiration of its license to transact the kinds of insurance to which said  
1268 sections 38a-836 to 38a-853, inclusive, apply, however such insurer shall  
1269 remain liable as a member insurer for any obligations, including  
1270 obligations for assessments levied prior to the termination or expiration  
1271 of the insurer's license and for assessments levied after the termination  
1272 or expiration which relate to any insurer which became an insolvent  
1273 insurer prior to the termination or expiration of such insurer's license.

1274 In the case of such insurer, the average of its net direct written premium  
1275 for the five calendar years prior to expiration or termination of its  
1276 license, whether or not the insurer has net direct written premium in the  
1277 year preceding such expiration or termination, shall be used as its  
1278 assessment base for any year following such expiration or termination  
1279 in which the insurer has no direct written premium;

1280 [(8)] (9) "Net direct written premiums" means direct gross premiums  
1281 written in this state on insurance policies to which sections 38a-836 to  
1282 38a-853, inclusive, apply, less return premiums thereon and dividends  
1283 paid or credited to policyholders on such direct business, provided the  
1284 term "net direct written premiums" shall not include premiums on any  
1285 contract between insurers or reinsurers;

1286 [(9)] (10) "Person" means an individual, corporation, partnership,  
1287 association, joint stock company, business trust, limited liability  
1288 company, unincorporated organization, voluntary organization,  
1289 governmental entity or other legal entity;

1290 [(10)] (11) "Residence" means, when used in reference to a  
1291 corporation, its principal place of business; and

1292 [(11)] (12) "United States" has the same meaning as provided in  
1293 section 38a-1.

1294 Sec. 20. Section 38a-841 of the general statutes is repealed and the  
1295 following is substituted in lieu thereof (*Effective October 1, 2026*):

1296 (a) Said association shall:

1297 (1) Be obligated to the extent of the covered claims existing prior to  
1298 the determination of insolvency or the entry of a final order of  
1299 liquidation with a finding of insolvency, as applicable, and arising  
1300 within thirty days after the determination of insolvency or the entry of  
1301 such order, or before the policy expiration date if less than thirty days  
1302 after the determination or the entry of such order, or before the insured

1303 replaces the policy or causes its cancellation if the insured does so within  
1304 thirty days after such determination or entry of such order, provided  
1305 such obligation shall be limited as follows: (A) With respect to covered  
1306 claims for unearned premiums [~~to one-half of the unearned premium~~  
1307 ~~on any policy,]~~ subject to a maximum of ~~[two]~~ fifty thousand dollars per  
1308 policy; (B) with respect to covered claims other than for unearned  
1309 premiums and those otherwise specified below, such obligation shall  
1310 include only that amount of each such claim that [~~is in excess of one~~  
1311 ~~hundred dollars and]~~ is less than or equal to (i) three hundred thousand  
1312 dollars for claims arising under policies of insurers determined to be  
1313 insolvent prior to October 1, 2007, (ii) four hundred thousand dollars for  
1314 claims arising under policies of insurers determined to be insolvent on  
1315 or after October 1, 2007, and prior to October 1, 2015, and (iii) five  
1316 hundred thousand dollars for claims arising under policies of insurers  
1317 against which a final order of liquidation with a finding of insolvency  
1318 has been entered by a court of competent jurisdiction in the insurer's  
1319 state of domicile on or after October 1, 2015; (C) with respect to first-  
1320 party real property claims arising under policies of insurers determined  
1321 to be insolvent on or after June 1, 2026, an amount not exceeding one  
1322 million dollars for claims arising from a single occurrence under a policy  
1323 covering commercial or residential property; (D) in no event shall the  
1324 association be obligated to pay an amount in excess of five hundred  
1325 thousand dollars for all first and third-party claims under a policy or  
1326 endorsement providing, or that is found to provide, cybersecurity  
1327 insurance coverage and arising out of or related to a single insured  
1328 event, regardless of the number of claims made or the number of  
1329 claimants. Said association shall pay the full amount of any such claim  
1330 arising out of a workers' compensation policy, provided in no event  
1331 shall said association be obligated ~~[(I)]~~ (i) to any claimant in an amount  
1332 in excess of the obligation of the insolvent insurer under the policy form  
1333 or coverage from which the claim arises, or ~~[(II)]~~ (ii) for any claim filed  
1334 with the association after the expiration of two years from the date of  
1335 the declaration of insolvency unless such claim arose out of a workers'  
1336 compensation policy and was timely filed in accordance with section 31-

1337 294c;

1338 (2) Be deemed the insurer to the extent of its obligations on the  
1339 covered claims and to such extent shall have all rights, duties, and  
1340 obligations of the insolvent insurer as if the insurer had not become  
1341 insolvent, including, but not limited to, the right to pursue and retain  
1342 salvage and subrogation recoverable on covered claim obligations to the  
1343 extent paid by the association, provided the association shall not be  
1344 deemed the insolvent insurer for the purpose of conferring jurisdiction;

1345 (3) Allocate claims paid and expenses incurred among the three  
1346 accounts, created by section 38a-839, separately, and assess member  
1347 insurers separately (A) in respect of each such account for such amounts  
1348 as shall be necessary to pay the obligations of said association under  
1349 subdivision (1) of this subsection subsequent to an insolvency; (B) the  
1350 expenses of handling covered claims subsequent to an insolvency; (C)  
1351 the cost of examinations under section 38a-846; and (D) such other  
1352 expenses as are authorized by sections 38a-836 to 38a-853, inclusive. The  
1353 assessments of each member insurer shall be in the proportion that the  
1354 net direct written premiums of such member insurer for the calendar  
1355 year preceding the assessment on the kinds of insurance in such account  
1356 bears to the net direct written premiums of all member insurers for the  
1357 calendar year preceding the assessment on the kinds of insurance in  
1358 such account. Each member insurer shall be notified of its assessment  
1359 not later than thirty days before it is due. No member insurer may be  
1360 assessed in any year on any account an amount greater than two per  
1361 cent of that member insurer's net direct written premiums for the  
1362 calendar year preceding the assessment on the kinds of insurance in said  
1363 account, provided if, at the time an assessment is levied on the all other  
1364 insurance account, as defined in subdivision (3) of section 38a-839, the  
1365 board of directors finds that at least fifty per cent of the total net direct  
1366 written premiums of a member insurer and all its affiliates, for the year  
1367 on which such assessment is based, were from policies issued or  
1368 delivered in Connecticut, on risks located in this state, such member  
1369 insurer shall be assessed only on such member insurer's net direct

1370 written premium that is attributable to the kind of insurance that gives  
1371 rise to each covered claim. If the maximum assessment, together with  
1372 the other assets of said association in any account, does not provide in  
1373 any one year in any account an amount sufficient to make all necessary  
1374 payments from that account, the funds available may be prorated and  
1375 the unpaid portion shall be paid as soon thereafter as funds become  
1376 available. Said association may defer, in whole or in part, the assessment  
1377 of any member insurer if the assessment would cause the member  
1378 insurer's financial statement to reflect amounts of capital or surplus less  
1379 than the minimum amounts required for a certificate of authority by any  
1380 jurisdiction in which the member insurer is authorized to transact  
1381 insurance, provided during the period of deferment, no dividends shall  
1382 be paid to shareholders or policyholders. Deferred assessments shall be  
1383 paid when such payment will not reduce capital or surplus below the  
1384 minimum amounts required for a certificate of authority. Such  
1385 payments shall be refunded to those insurers receiving greater  
1386 assessments because of such deferment or, at the election of the insurer,  
1387 be credited against future assessments. Each member insurer serving as  
1388 a servicing facility may set off against any assessment, authorized  
1389 payments made on covered claims and expenses incurred in the  
1390 payment of such claims by such member insurer if they are chargeable  
1391 to the account in respect of which the assessment is made;

1392 (4) Investigate claims brought against said association and adjust,  
1393 compromise, settle, and pay covered claims to the extent of said  
1394 association's obligations and deny all other claims. The association shall  
1395 pay claims in any order it deems reasonable including, but not limited  
1396 to, payment in the order of receipt or by classification. It may review  
1397 settlements, releases and judgments to which the insolvent insurer or its  
1398 insureds were parties to determine the extent to which such settlements,  
1399 releases and judgments may be properly contested;

1400 (5) Notify such persons as the commissioner may direct under  
1401 subdivision (1) of subsection (b) of section 38a-843;

1402 (6) Handle claims through its employees or through one or more  
1403 insurers or other persons designated by said association as servicing  
1404 facilities, provided such designation of a servicing facility is approved  
1405 by the commissioner and may be declined by a member insurer;

1406 (7) Reimburse each such servicing facility for obligations of said  
1407 association paid by such facility and for expenses incurred by such  
1408 facility while handling claims on behalf of said association and shall pay  
1409 such other expenses of said association as are authorized by sections  
1410 38a-836 to 38a-853, inclusive.

1411 (b) Said association may: (1) Employ or retain such persons as are  
1412 necessary to handle claims and perform other duties of said association  
1413 and shall have the right to appoint and direct legal counsel retained  
1414 under liability insurance policies for the defense of covered claims and  
1415 to appoint and direct other service providers for covered services; (2)  
1416 borrow such funds as may be necessary from time to time to effect the  
1417 purposes of sections 38a-836 to 38a-853, inclusive, in accord with the  
1418 plan of operation under section 38a-842; (3) sue or be sued; (4) intervene  
1419 as a matter of right as a party in any proceeding before any court in this  
1420 state that has jurisdiction over an insolvent insurer, as defined in section  
1421 38a-838, as amended by this act; (5) negotiate and become a party to such  
1422 contracts as are necessary to carry out the purpose of sections 38a-836 to  
1423 38a-853, inclusive; (6) perform such other acts as are necessary or proper  
1424 to effectuate the purpose of said sections; (7) refund to the member  
1425 insurers in proportion to the contribution of each such member insurer  
1426 to that account, that amount by which the assets of the account exceed  
1427 the liabilities, if, at the end of any calendar year, the board of directors  
1428 finds that the assets of said association in any account exceed the  
1429 liabilities of that account as estimated by the board of directors for the  
1430 coming year.

1431 (c) (1) Each insurer paying an assessment under sections 38a-836 to  
1432 38a-853, inclusive, may offset one hundred per cent of the amount of  
1433 such assessment against its premium tax liability to this state under

1434 chapter 207. Such offset shall be taken over a period of the five  
1435 successive tax years following the year of payment of the assessment, at  
1436 the rate of twenty per cent per year of the assessment paid to the  
1437 association. Each insurer to which has been refunded by the association,  
1438 pursuant to subsection (b) of this section, all or a portion of an  
1439 assessment previously paid to the association by the insurer shall be  
1440 required to pay to the Department of Revenue Services an amount equal  
1441 to the total amount that has been claimed as an offset against the  
1442 premiums tax liability on the premiums tax return or returns, as the case  
1443 may be, filed by such insurer and that is attributable to such refunded  
1444 assessment, provided the amount required to be paid to said  
1445 department shall not exceed the amount of the refunded assessment. If  
1446 the amount of the refunded assessment exceeds the total amount that  
1447 has been claimed as an offset against the premiums tax liability on the  
1448 premiums tax return or returns filed by such insurer and that is  
1449 attributable to such refunded assessment, such excess may not be  
1450 claimed as an offset against the premiums tax liability on a premiums  
1451 tax return or returns filed by such insurer or, if the offset has been  
1452 transferred to another person pursuant to subdivision (2) of this  
1453 subsection, by such other person. For purposes of this subparagraph, if  
1454 the offset has been transferred to another person pursuant to  
1455 subdivision (2) of this subsection, the total amount that has been claimed  
1456 as an offset against the premiums tax liability on the premiums tax  
1457 return or returns filed by such insurer includes the total amount that has  
1458 been claimed as an offset against the premiums tax liability on the  
1459 premiums tax return or returns filed by such other person. The  
1460 association shall promptly notify the Commissioner of Revenue Services  
1461 of the name and address of the insurers to which such refunds have been  
1462 made, the amount of such refunds and the date on which such refunds  
1463 were mailed to such insurer. If the amount that an insurer is required to  
1464 pay to the Department of Revenue Services has not been so paid on or  
1465 before the forty-fifth day after the date of mailing of such refunds, the  
1466 insurer shall be liable for interest on such amount at the rate of one per  
1467 cent per month or fraction thereof from such forty-fifth day to the date

1468 of payment.

1469 (2) An insurer, in this subparagraph called "the transferor", may  
1470 transfer any offset provided under subdivision (1) of this subsection to  
1471 an affiliate, as defined in section 38a-1, of the transferor. Any such  
1472 transfer of the offset by the transferor and any subsequent transfer or  
1473 transfers of the same offset shall not affect the obligation of the  
1474 transferor to pay to the Department of Revenue Services any sums  
1475 which are acquired by refund from the association pursuant to  
1476 subsection (b) of this section and which are required to be paid to the  
1477 Department of Revenue Services pursuant to subdivision (1) of this  
1478 subsection. Such offset may be taken by any transferee only against the  
1479 transferee's premium tax liability to this state under chapter 207. The  
1480 Commissioner of Revenue Services shall not allow such offset to a  
1481 transferee against its premium tax liability unless the transferor, the  
1482 affiliate to which the offset was originally transferred, each subsequent  
1483 transferor and each subsequent transferee have filed such information  
1484 as may be required on forms provided by said commissioner with  
1485 respect to any such transfer or transfers on or before the due date of the  
1486 premium tax return on which such offset would have been taken by the  
1487 transferor if no transfer had been made by the transferor.

1488 Sec. 21. Subsection (a) of section 38a-860 of the general statutes is  
1489 repealed and the following is substituted in lieu thereof (*Effective October*  
1490 *1, 2026*):

1491 (a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for  
1492 the policies and contracts specified in subsection (f) of this section: (1)  
1493 To any person, except for a nonresident certificate holder under a group  
1494 policy or contract, who is the beneficiary, assignee or payee, including a  
1495 health care provider rendering services covered under a health  
1496 insurance policy or certificate, of the person covered under subdivision  
1497 (2) of this subsection, regardless of where the person resides, and (2) any  
1498 person who is the owner of, or certificate holder or enrollee under, such  
1499 policy or contract, other than an unallocated annuity contract or a

1500 structured settlement annuity, and in each case who (A) is a resident, or  
1501 (B) is not a resident, provided (i) the member insurer that issued such  
1502 policy or contract is domiciled in this state, (ii) the state in which the  
1503 person resides has an association similar to the association created by  
1504 this section and sections 38a-837, 38a-838, as amended by this act, 38a-  
1505 845, 38a-853, 38a-859, 38a-862, 38a-863, 38a-865, and 38a-866, and (iii) the  
1506 person is not eligible for coverage by an association in any other state  
1507 because the insurer was not licensed in the state in which the person  
1508 resides at the time specified in the state's guaranty association law,  
1509 unless the assumption of the obligation was effected pursuant to  
1510 subsection (g) of section 22 of this act.

1511       Sec. 22. (NEW) (*Effective October 1, 2026*):

1512       (a) As used in this section:

1513           (1) "Assuming insurer" means the insurer that acquires an insurance  
1514 obligation or risk, or both, from the transferring insurer pursuant to an  
1515 assumption reinsurance agreement.

1516           (2) "Assumption reinsurance agreement" means any contract that  
1517 both (A) transfers insurance obligations or risks, or both, of existing or  
1518 in-force contracts of insurance from a transferring insurer to an  
1519 assuming insurer, and (B) is intended to effect a novation of the  
1520 transferred contract of insurance with the result that the assuming  
1521 insurer becomes directly liable to the policyholders of the transferring  
1522 insurer and the transferring insurer's insurance obligations or risks, or  
1523 both, under the contracts are extinguished.

1524           (3) "Contract of insurance" means any written agreement between an  
1525 insurer and policyholder pursuant to which the insurer, in exchange for  
1526 premium or other consideration, agrees to assume an obligation or risk,  
1527 or both, of the policyholder or to make payments on behalf of, or to, the  
1528 policyholder or its beneficiaries. "Contract of insurance" includes all  
1529 property, casualty, life, health, accident, surety, title and annuity  
1530 business authorized to be written pursuant to the insurance laws of the

1531 state.

1532 (4) "Home service business" means an insurance business for which  
1533 premiums are collected on a weekly or monthly basis by an agent of the  
1534 insurer.

1535 (5) "Notice of transfer" means the written notice to policyholders  
1536 required by subsection (c) of this section.

1537 (6) "Policyholder" means any individual or entity that has the right to  
1538 terminate or otherwise alter the terms of a contract of insurance.  
1539 "Policyholder" includes any certificate holder whose certificate is in  
1540 force on the proposed effective date of the assumption, if the certificate  
1541 holder has the right to keep the certificate in force without change in  
1542 benefit following termination of the group policy. The right to keep the  
1543 certificate in force referred to in this section shall not include the right  
1544 to elect individual coverage under the Consolidated Omnibus Budget  
1545 Reconciliation Act, Section 601, et seq., of the Employee Retirement  
1546 Income Security Act of 1974, as amended (29 USC 1161 et seq.).

1547 (7) "Transferring insurer" means the insurer that transfers an  
1548 insurance obligation or risk, or both, to an assuming insurer pursuant to  
1549 an assumption reinsurance agreement.

1550 (b) (1) This section applies to any insurer authorized in the state that  
1551 either assumes or transfers the obligations or risks, or both, on contracts  
1552 of insurance pursuant to an assumption reinsurance agreement.

1553 (2) This section does not apply to:

1554 (A) Any reinsurance agreement or transaction in which the ceding  
1555 insurer continues to remain directly liable for its insurance obligations  
1556 or risks, or both, under the contracts of insurance subject to the  
1557 reinsurance agreement;

1558 (B) The substitution of one insurer for another upon the expiration of  
1559 insurance coverage pursuant to statutory or contractual requirements

1560 and the issuance of a new contract of insurance by another insurer;

1561 (C) The transfer of contracts of insurance pursuant to mergers or  
1562 consolidations of two or more insurers to the extent that those  
1563 transactions are regulated by statute;

1564 (D) Any insurer subject to a judicial order of liquidation or  
1565 rehabilitation;

1566 (E) Any reinsurance agreement or transaction to which a state  
1567 insurance guaranty association is a party, provided policyholders do not  
1568 lose any rights or claims afforded under their original policies pursuant  
1569 to chapter 704A of the general statutes; or

1570 (F) The transfer of liabilities from one insurer to another under a  
1571 single group policy upon the request of the group policyholder.

1572 (c) (1) The transferring insurer shall provide or cause to be provided  
1573 to each policyholder a notice of transfer by first-class mail, addressed to  
1574 the policyholder's last-known address or to the address to which  
1575 premium notices or other policy documents are sent or, with respect to  
1576 home service business, by personal delivery with acknowledged receipt.  
1577 A notice of transfer shall also be sent to the transferring insurer's agents  
1578 or brokers of record on the affected policies.

1579 (2) The notice of transfer shall state or provide:

1580 (A) The date the transfer and novation of the policyholder's contract  
1581 of insurance is proposed to take place;

1582 (B) The name, address and telephone number of the assuming and  
1583 transferring insurer;

1584 (C) That the policyholder has the right to either consent to or reject  
1585 the transfer and novation;

1586 (D) The procedures and time limit for consenting to or rejecting the

1587 transfer and novation;

1588 (E) A summary of any effect that consenting to or rejecting the  
1589 transfer and novation will have on the policyholder's rights;

1590 (F) A statement that the assuming insurer is licensed to write the type  
1591 of business being assumed in the state where the policyholder resides,  
1592 or is otherwise authorized, as provided herein, to assume such business;

1593 (G) The name and address of the person at the transferring insurer to  
1594 whom the policyholder should send its written statement of acceptance  
1595 or rejection of the transfer and novation;

1596 (H) The address and telephone number of the insurance department  
1597 where the policyholder resides so that the policyholder may write or call  
1598 the insurance department for further information regarding the  
1599 financial condition of the assuming insurer; and

1600 (I) The following financial data for both companies:

1601 (i) Ratings for the last five years, if available, or for such lesser period  
1602 as is available from two nationally recognized insurance rating services  
1603 acceptable to the commissioner, including the rating service's  
1604 explanation of the meaning of the ratings. If ratings are unavailable for  
1605 any year of the five-year period, this shall also be disclosed;

1606 (ii) A balance sheet as of December thirty-first for the previous three  
1607 years, if available, or for such lesser period as is available and as of the  
1608 date of the most recent quarterly statement;

1609 (iii) A copy of the Management's Discussion and Analysis that was  
1610 filed as a supplement to the previous year's annual statement; and

1611 (iv) An explanation of the reason for the transfer.

1612 (3) Notice in a form prescribed by the commissioner under subsection  
1613 (h) of this section or a substantially similar notice shall be deemed to

1614 comply with the requirements of subdivision (2) of subsection (c) of this  
1615 section.

1616 (4) The notice of transfer shall include a pre-addressed, postage-paid  
1617 response card that a policyholder may return as its written statement of  
1618 acceptance or rejection of the transfer and novation.

1619 (5) The notice of transfer shall be filed as part of the prior approval  
1620 requirement set forth in subdivision (1) of subsection (d) of this section.

1621 (d) (1) Prior approval by the commissioner is required for any  
1622 transaction where an insurer domiciled in this state assumes or transfers  
1623 obligations or risks, or both, on contracts of insurance under an  
1624 assumption reinsurance agreement. No insurer licensed in this state  
1625 shall transfer obligations or risks, or both, on contracts of insurance  
1626 issued to or owned by residents of this state to any insurer that is not  
1627 licensed in this state. An insurer domiciled in this state shall not assume  
1628 obligations or risks, or both, on contracts of insurance issued to or  
1629 owned by policyholders residing in any other state unless it is licensed  
1630 in the other state, or the insurance regulatory official of that state has  
1631 approved the assumption.

1632 (2) Any licensed foreign insurer that enters into an assumption  
1633 reinsurance agreement that transfers the obligations or risks, or both, on  
1634 contracts of insurance issued to or owned by residents of this state shall  
1635 file or cause to be filed with the commissioner of insurance of this state  
1636 the assumption certificate, a copy of the notice of transfer and an  
1637 affidavit that the transaction is subject to substantially similar  
1638 requirements in the state of domicile of both the transferring and  
1639 assuming insurer. If no such requirements exist in the domicile of either  
1640 the transferring or assuming insurers, the requirements of subdivision  
1641 (3) of subsection (d) of this section shall apply.

1642 (3) Any licensed foreign insurer that enters into an assumption  
1643 reinsurance agreement that transfers the obligations or risks, or both, on  
1644 contracts of insurance issued to or owned by residents of this state shall

1645 obtain prior approval of the commissioner of insurance of this state and  
1646 be subject to all other requirements of this section with respect to  
1647 residents of this state, unless the transferring and assuming insurers are  
1648 subject to assumption reinsurance requirements adopted by statute or  
1649 regulation in the jurisdiction of their domicile that are substantially  
1650 similar to those contained herein.

1651 (4) The following factors, along with such other factors as the  
1652 commissioner deems appropriate under the circumstances, shall be  
1653 considered by the commissioner in reviewing a request for approval:

1654 (A) The financial condition of the transferring and assuming insurers  
1655 and the effect the transaction will have on the financial condition of each  
1656 company;

1657 (B) The competence, experience and integrity of those persons who  
1658 control the operation of the assuming insurer;

1659 (C) The plans or proposals the assuming party has with respect to the  
1660 administration of the policies subject to the proposed transfer;

1661 (D) Whether the transfer is fair and reasonable to the policyholders  
1662 of both companies; and

1663 (E) Whether the notice of transfer to be provided by the insurer is fair,  
1664 adequate and not misleading.

1665 (e) (1) Policyholders shall have the right to reject the transfer and  
1666 novation of their contracts of insurance. Policyholders electing to reject  
1667 the assumption transaction shall return to the transferring insurer the  
1668 pre-addressed, postage-paid response card or other written notice and  
1669 indicate thereon that the assumption is rejected (collectively referred to  
1670 as the "Response Card").

1671 (2) Payment of any premium to the assuming company during the  
1672 twenty-four-month period after notice is received shall be deemed to  
1673 indicate the policyholder's acceptance of the transfer to the assuming

1674 insurer and a novation shall be deemed to have been effected, provided  
1675 the premium notice clearly states that payment of the premium to the  
1676 assuming insurer shall constitute acceptance of the transfer. However,  
1677 the premium notice shall also provide a method for the policyholder to  
1678 pay the premium while reserving the right to reject the transfer. With  
1679 respect to any home service business or any other business not using  
1680 premium notices, the disclosures and procedural requirements of this  
1681 subsection are to be set forth in the notice of transfer required by  
1682 subsections (c) and (d) of this section and in the assumption certificate.

1683 (3) After no fewer than twenty-four months from the mailing of the  
1684 initial notice of transfer required under subsection (c) of this section, if  
1685 positive consent to, or rejection of, the transfer and assumption has not  
1686 been received or consent has not been deemed to have occurred under  
1687 subdivision (2) of subsection (e) of this section, the transferring  
1688 company shall send to the policyholder a second and final notice of  
1689 transfer as specified in subsection (c) of this section. If the policyholder  
1690 does not accept or reject the transfer during the one-month period  
1691 immediately following the date on which the transferring insurer mails  
1692 the second and final notice of transfer, the policyholder's consent will be  
1693 deemed to have occurred and novation of the contract will be effected.  
1694 With respect to the home service business, or any other business not  
1695 using premium notices, the twenty-four and one-month periods shall be  
1696 measured from the date of delivery of the notice of transfer pursuant to  
1697 subdivision (1) of subsection (c) of this section.

1698 (4) The transferring insurer will be deemed to have received the  
1699 Response Card on the date it is postmarked. A policyholder may also  
1700 send its Response Card by facsimile or other electronic transmission or  
1701 by registered mail, express delivery or courier service, in which case the  
1702 Response Card shall be deemed to have been received by the assuming  
1703 insurer on the date of actual receipt by the transferring insurer.

1704 (f) If a policyholder consents to the transfer pursuant to subsection (e)  
1705 of this section or if the transfer is effected under subsection (g) of this

1706 section, there shall be a novation of the contract of insurance subject to  
 1707 the assumption reinsurance agreement with the result that the  
 1708 transferring insurer shall thereby be relieved of all insurance obligations  
 1709 or risks, or both, transferred under the assumption reinsurance  
 1710 agreement and the assuming insurer shall become directly and solely  
 1711 liable to the policyholder for those insurance obligations or risks, or  
 1712 both.

1713 (g) If an insurer domiciled in this state or in a jurisdiction having a  
 1714 substantially similar law is deemed by the domiciliary commissioner to  
 1715 be in hazardous financial condition or an administrative proceeding has  
 1716 been instituted against it for the purpose of reorganizing or conserving  
 1717 the insurer, and the transfer of the contracts of insurance is in the best  
 1718 interest of the policyholders, as determined by the domiciliary  
 1719 commissioner, a transfer and novation may be effected notwithstanding  
 1720 the provisions of this section. This may include a form of implied  
 1721 consent and adequate notification to the policyholder of the  
 1722 circumstances requiring the transfer as approved by the commissioner.

1723 (h) The commissioner may adopt regulations, in accordance with  
 1724 chapter 54 of the general statutes, to establish the form of notice of  
 1725 transfer required in this section.

1726 Sec. 23. Section 38a-66 of the general statutes is repealed. (*Effective*  
 1727 *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>upon passage</i>	38a-307a
Sec. 7	<i>October 1, 2026</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
Sec. 14	<i>October 1, 2026</i>	38a-708
Sec. 15	<i>October 1, 2026</i>	38a-720a
Sec. 16	<i>October 1, 2026</i>	38a-720e
Sec. 17	<i>October 1, 2026</i>	38a-792(b)
Sec. 18	<i>October 1, 2026</i>	38a-837
Sec. 19	<i>October 1, 2026</i>	38a-838
Sec. 20	<i>October 1, 2026</i>	38a-841
Sec. 21	<i>October 1, 2026</i>	38a-860(a)
Sec. 22	<i>October 1, 2026</i>	New section
Sec. 23	<i>October 1, 2026</i>	Repealer section

**Statement of Purpose:**

To implement the Insurance Department's recommendations for revisions to the insurance statutes.

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