



General Assembly

Substitute Bill No. 5373

February Session, 2026



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

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

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 Section 38a-26 of the general statutes is repealed and the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

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

9 (b) The commissioner shall immediately send by registered, [or]
10 certified or electronic mail one copy of the process to the person to be
11 served as follows: (1) To that person's last-known principal place of
12 business, residence, [or] post-office address or electronic mail address,
13 or (2) if a foreign insurance company, to the secretary of the company or
14 designee of the company, or (3) if an alien insurance company, to the
15 resident manager, if any, in this country, or (4) if a fraternal benefit
16 society, to the secretary or corresponding officer of the society. Service
17 by electronic mail as provided in this subsection shall be made to the

18 last-known electronic mail address of the person, secretary, designee,
19 resident manager, secretary or officer to be notified, as applicable, as
20 filed with and maintained by the commissioner.

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

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

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

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

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

44 (b) Notwithstanding the provisions of subsection (c) of section 4-182,
45 the commissioner may provide notice of suspension or revocation of a
46 license pursuant to this section or section 4-182 to any person licensed
47 by or registered with the commissioner by personal delivery, as defined
48 in section 4-166. For any firm, association or corporation licensed by or

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

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

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

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

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

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

107 (5) (A) Not later than December first, annually, the Insurance
108 Commissioner shall submit a statement to each such insurer, health care
109 center, third-party administrator and exempt insurer that includes the
110 proposed fee, identified on such statement as the "Health and Welfare
111 fee", for the insurer, health care center, third-party administrator or
112 exempt insurer calculated in accordance with this subsection. Not later
113 than December twentieth, annually, any insurer, health care center,
114 third-party administrator or exempt insurer may submit an objection to
115 the commissioner concerning the proposed fee. The commissioner, after

116 making any adjustment that the commissioner deems necessary, shall,
117 not later than January first, annually, submit a final statement to each
118 insurer, health care center, third-party administrator and exempt
119 insurer that includes the final fee for the insurer, health care center,
120 third-party administrator or exempt insurer. Each such insurer, health
121 care center, third-party administrator and exempt insurer shall pay such
122 fee to the Insurance Commissioner not later than February first,
123 annually.

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

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

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

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

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

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

165 (3) The proposed assessment against that company or entity,
166 calculated in accordance with the provisions of subsection (c) of this
167 section, provided for the purposes of this calculation the amount
168 appropriated to the Insurance Department, the Office of the Healthcare
169 Advocate, the Office of the Behavioral Health Advocate and the Office
170 of Health Strategy from the Insurance Fund plus the cost of fringe
171 benefits for department and office personnel and the estimated
172 expenditures on behalf of the department and said offices from the
173 Capital Equipment Purchase Fund pursuant to section 4a-9, not
174 including such expenditures made on behalf of the Health Systems
175 Planning Unit of the Office of Health Strategy shall be deemed to be the
176 actual expenditures of the department and said offices, and the amount
177 appropriated to the Department of Aging and Disability Services from
178 the Insurance Fund for the fiscal year for the fall prevention program
179 established in section 17a-859 shall be deemed to be the actual
180 expenditures for the program.

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

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

215 Advocate and the Office of Health Strategy from the Insurance Fund.
216 The provisions of this subdivision shall not be applicable to any
217 corporation that has converted to a domestic mutual insurance
218 company pursuant to section 38a-155 upon the effective date of any
219 public act that amends said section to modify or remove any restriction
220 on the business such a company may engage in, for purposes of any
221 assessment due from such company on and after such effective date.

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

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

246 (f) If the actual expenditures for the fall prevention program
247 established in section 17a-859 are less than the amount allocated, the

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

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

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

280 Sec. 6. Section 38a-307a of the general statutes is repealed and the

281 following is substituted in lieu thereof (*Effective from passage*):

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

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

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

314 on the rates and rules applicable to the ensuing policy period, and [shall]
315 (C) include a notice of transfer when the policy has been transferred
316 from an insurer to an affiliate of such insurer pursuant to the provisions
317 of subparagraph (C) of subdivision (1) of subsection (a) of this section.
318 As used herein, "reasonable explanation" means sufficient information,
319 in terms that are understandable to an average policyholder, which
320 enables the policyholder to determine the basic nature of any premium
321 increase. The provisions of this subsection shall apply to any such policy
322 for which the annual premium was less than fifty thousand dollars for
323 the preceding annual policy period.

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

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

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

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

346 dollars. The Insurance Commissioner may authorize an extension of
347 time for compliance with the provisions of this subdivision, not to
348 exceed December 1, 2029, if the Insurance Commissioner determines
349 additional time is necessary for such compliance. The provisions of this
350 subdivision shall not apply to premium increases of one hundred
351 dollars or less. The Insurance Commissioner shall adopt regulations, in
352 accordance with the provisions of chapter 54, to implement the
353 provision of this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

469 (a) For the purposes of this section:

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

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

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

475 plan as such term is used in the Affordable Care Act;

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

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

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

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

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

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

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

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

502 (A) The federal Food and Drug Administration issues an
503 announcement, guidance, notice, warning or statement concerning the

504 prescription drug that calls into question the clinical safety of the
505 prescription drug, unless the covered person's treating physician states,
506 in writing, that the prescription drug remains medically necessary
507 despite such announcement, guidance, notice, warning or statement; or

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

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

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

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

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

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

531 [(e)] (f) (1) The Office of Health Strategy shall, at least annually,
532 conduct a study to determine the impact that the requirements
533 established in subsections (a) to [(d)] (e), inclusive, of this section have

534 on the cost of health benefit plans offered, delivered, issued for delivery,
535 renewed, amended or continued in this state and qualified health plans
536 offered and sold through the exchange.

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

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

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

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

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

574 (C) If the request:

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

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

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

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

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

597 2026):

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

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

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

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

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

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

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

640 (2) Such notice shall include:

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

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

646 (C) The date the review was conducted;

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

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

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

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

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

657 investigational:

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

659 (ii) A description of the indicators relevant to determining whether
660 there is sufficient evidence to demonstrate that (I) the recommended or
661 requested health care service or treatment is likely to be more beneficial
662 to the covered person than any available standard health care services
663 or treatments, and (II) the adverse risks of the recommended or
664 requested health care service or treatment would not be substantially
665 increased over those of available standard health care services or
666 treatments;

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

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

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

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

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

680 Upon the request of the Insurance Commissioner, any insurance
681 company shall furnish to the Insurance Department the facts relative to
682 the termination of an agent's appointment and the causes thereof. If a
683 company terminates an agent's appointment for cause, such termination
684 shall be reported to the commissioner not later than thirty calendar days
685 after such termination. No agent shall have a cause of action against any
686 insurance company as a result of such company's having furnished to

687 said department pursuant to this section any statement, oral or written,
688 unless such statement is false and was known by such company to be
689 false when made.

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

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

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

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

719 insurance and the business of insurance as provided for in 29 USC 1144,
720 as amended from time to time.

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

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

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

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

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

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

750 account maintained in the name of the insurer or other person utilizing
751 the services of the third-party administrator, (C) transfer to and deposit
752 in a claims-paying account, with claims to be paid as provided for in
753 subsection (d) of section 38a-720f, (D) payment to a group policyholder
754 for remittance to the insurer or other person utilizing the services of the
755 third-party administrator entitled to such remittance, (E) payment to the
756 third-party administrator for its commissions, fees or charges, and (F)
757 remittance of return premiums to the person or persons entitled to such
758 return premiums;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

823 (5) [Insurance] Except for coverages that may be set forth in a
824 cybersecurity policy, insurance of warranties or service contracts,
825 including insurance that provides for the repair, replacement or service
826 of goods or property, or indemnification for repair, replacement or
827 service, for the operational or structural failure of the goods or property
828 due to a defect in materials, workmanship or normal wear and tear, or
829 that provides reimbursement for the liability incurred by the issuer of
830 agreements or service contracts that provide such benefits;

831 (6) Title insurance;

832 (7) Ocean marine insurance;

833 (8) Any transaction or combination of transactions between a person,
834 including affiliates of such person, and an insurer, including affiliates of
835 such insurer, which involves the transfer of investment or credit risk
836 unaccompanied by transfer of insurance risk;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

974 [(8)] (9) "Net direct written premiums" means direct gross premiums
975 written in this state on insurance policies to which sections 38a-836 to

976 38a-853, inclusive, apply, less return premiums thereon and dividends
977 paid or credited to policyholders on such direct business, provided the
978 term "net direct written premiums" shall not include premiums on any
979 contract between insurers or reinsurers;

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

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

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

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

990 (a) Said association shall:

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

1007 insolvent prior to October 1, 2007, (ii) four hundred thousand dollars for
1008 claims arising under policies of insurers determined to be insolvent on
1009 or after October 1, 2007, and prior to October 1, 2015, and (iii) five
1010 hundred thousand dollars for claims arising under policies of insurers
1011 against which a final order of liquidation with a finding of insolvency
1012 has been entered by a court of competent jurisdiction in the insurer's
1013 state of domicile on or after October 1, 2015; (C) with respect to first-
1014 party real property claims arising under policies of insurers determined
1015 to be insolvent on or after June 1, 2026, an amount not exceeding one
1016 million dollars for claims arising from a single occurrence under a policy
1017 covering commercial or residential property; (D) in no event shall the
1018 association be obligated to pay an amount in excess of five hundred
1019 thousand dollars for all first and third-party claims under a policy or
1020 endorsement providing, or that is found to provide, cybersecurity
1021 insurance coverage and arising out of or related to a single insured
1022 event, regardless of the number of claims made or the number of
1023 claimants. Said association shall pay the full amount of any such claim
1024 arising out of a workers' compensation policy, provided in no event
1025 shall said association be obligated [(I)] (i) to any claimant in an amount
1026 in excess of the obligation of the insolvent insurer under the policy form
1027 or coverage from which the claim arises, or [(II)] (ii) for any claim filed
1028 with the association after the expiration of two years from the date of
1029 the declaration of insolvency unless such claim arose out of a workers'
1030 compensation policy and was timely filed in accordance with section 31-
1031 294c;

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

1039 (3) Allocate claims paid and expenses incurred among the three
1040 accounts, created by section 38a-839, separately, and assess member

1041 insurers separately (A) in respect of each such account for such amounts
1042 as shall be necessary to pay the obligations of said association under
1043 subdivision (1) of this subsection subsequent to an insolvency; (B) the
1044 expenses of handling covered claims subsequent to an insolvency; (C)
1045 the cost of examinations under section 38a-846; and (D) such other
1046 expenses as are authorized by sections 38a-836 to 38a-853, inclusive. The
1047 assessments of each member insurer shall be in the proportion that the
1048 net direct written premiums of such member insurer for the calendar
1049 year preceding the assessment on the kinds of insurance in such account
1050 bears to the net direct written premiums of all member insurers for the
1051 calendar year preceding the assessment on the kinds of insurance in
1052 such account. Each member insurer shall be notified of its assessment
1053 not later than thirty days before it is due. No member insurer may be
1054 assessed in any year on any account an amount greater than two per
1055 cent of that member insurer's net direct written premiums for the
1056 calendar year preceding the assessment on the kinds of insurance in said
1057 account, provided if, at the time an assessment is levied on the all other
1058 insurance account, as defined in subdivision (3) of section 38a-839, the
1059 board of directors finds that at least fifty per cent of the total net direct
1060 written premiums of a member insurer and all its affiliates, for the year
1061 on which such assessment is based, were from policies issued or
1062 delivered in Connecticut, on risks located in this state, such member
1063 insurer shall be assessed only on such member insurer's net direct
1064 written premium that is attributable to the kind of insurance that gives
1065 rise to each covered claim. If the maximum assessment, together with
1066 the other assets of said association in any account, does not provide in
1067 any one year in any account an amount sufficient to make all necessary
1068 payments from that account, the funds available may be prorated and
1069 the unpaid portion shall be paid as soon thereafter as funds become
1070 available. Said association may defer, in whole or in part, the assessment
1071 of any member insurer if the assessment would cause the member
1072 insurer's financial statement to reflect amounts of capital or surplus less
1073 than the minimum amounts required for a certificate of authority by any
1074 jurisdiction in which the member insurer is authorized to transact
1075 insurance, provided during the period of deferment, no dividends shall

1076 be paid to shareholders or policyholders. Deferred assessments shall be
1077 paid when such payment will not reduce capital or surplus below the
1078 minimum amounts required for a certificate of authority. Such
1079 payments shall be refunded to those insurers receiving greater
1080 assessments because of such deferment or, at the election of the insurer,
1081 be credited against future assessments. Each member insurer serving as
1082 a servicing facility may set off against any assessment, authorized
1083 payments made on covered claims and expenses incurred in the
1084 payment of such claims by such member insurer if they are chargeable
1085 to the account in respect of which the assessment is made;

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

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

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

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

1105 (b) Said association may: (1) Employ or retain such persons as are
1106 necessary to handle claims and perform other duties of said association
1107 and shall have the right to appoint and direct legal counsel retained

1108 under liability insurance policies for the defense of covered claims and
1109 to appoint and direct other service providers for covered services; (2)
1110 borrow such funds as may be necessary from time to time to effect the
1111 purposes of sections 38a-836 to 38a-853, inclusive, in accord with the
1112 plan of operation under section 38a-842; (3) sue or be sued; (4) intervene
1113 as a matter of right as a party in any proceeding before any court in this
1114 state that has jurisdiction over an insolvent insurer, as defined in section
1115 38a-838, as amended by this act; (5) negotiate and become a party to such
1116 contracts as are necessary to carry out the purpose of sections 38a-836 to
1117 38a-853, inclusive; (6) perform such other acts as are necessary or proper
1118 to effectuate the purpose of said sections; (7) refund to the member
1119 insurers in proportion to the contribution of each such member insurer
1120 to that account, that amount by which the assets of the account exceed
1121 the liabilities, if, at the end of any calendar year, the board of directors
1122 finds that the assets of said association in any account exceed the
1123 liabilities of that account as estimated by the board of directors for the
1124 coming year.

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

1142 premiums tax return or returns filed by such insurer and that is
1143 attributable to such refunded assessment, such excess may not be
1144 claimed as an offset against the premiums tax liability on a premiums
1145 tax return or returns filed by such insurer or, if the offset has been
1146 transferred to another person pursuant to subdivision (2) of this
1147 subsection, by such other person. For purposes of this subparagraph, if
1148 the offset has been transferred to another person pursuant to
1149 subdivision (2) of this subsection, the total amount that has been claimed
1150 as an offset against the premiums tax liability on the premiums tax
1151 return or returns filed by such insurer includes the total amount that has
1152 been claimed as an offset against the premiums tax liability on the
1153 premiums tax return or returns filed by such other person. The
1154 association shall promptly notify the Commissioner of Revenue Services
1155 of the name and address of the insurers to which such refunds have been
1156 made, the amount of such refunds and the date on which such refunds
1157 were mailed to such insurer. If the amount that an insurer is required to
1158 pay to the Department of Revenue Services has not been so paid on or
1159 before the forty-fifth day after the date of mailing of such refunds, the
1160 insurer shall be liable for interest on such amount at the rate of one per
1161 cent per month or fraction thereof from such forty-fifth day to the date
1162 of payment.

1163 (2) An insurer, in this subparagraph called "the transferor", may
1164 transfer any offset provided under subdivision (1) of this subsection to
1165 an affiliate, as defined in section 38a-1, of the transferor. Any such
1166 transfer of the offset by the transferor and any subsequent transfer or
1167 transfers of the same offset shall not affect the obligation of the
1168 transferor to pay to the Department of Revenue Services any sums
1169 which are acquired by refund from the association pursuant to
1170 subsection (b) of this section and which are required to be paid to the
1171 Department of Revenue Services pursuant to subdivision (1) of this
1172 subsection. Such offset may be taken by any transferee only against the
1173 transferee's premium tax liability to this state under chapter 207. The
1174 Commissioner of Revenue Services shall not allow such offset to a
1175 transferee against its premium tax liability unless the transferor, the

1176 affiliate to which the offset was originally transferred, each subsequent
1177 transferor and each subsequent transferee have filed such information
1178 as may be required on forms provided by said commissioner with
1179 respect to any such transfer or transfers on or before the due date of the
1180 premium tax return on which such offset would have been taken by the
1181 transferor if no transfer had been made by the transferor.

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

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

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

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

1208 assumption reinsurance agreement.

1209 (2) "Assumption reinsurance agreement" means any contract that (A)
1210 transfers insurance obligations or risks, or both, of existing or in-force
1211 contracts of insurance from a transferring insurer to an assuming
1212 insurer, and (B) is intended to effect a novation of the transferred
1213 contract of insurance with the result that the assuming insurer becomes
1214 directly liable to the policyholders of the transferring insurer and the
1215 transferring insurer's insurance obligations or risks, or both, under the
1216 contracts are extinguished.

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

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

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

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

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

1243 (b) (1) This section applies to any insurer authorized in the state that
1244 either assumes or transfers the obligations or risks, or both, on contracts
1245 of insurance pursuant to an assumption reinsurance agreement.

1246 (2) This section does not apply to:

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

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

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

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

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

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

1265 (c) (1) The transferring insurer shall provide or cause to be provided
1266 to each policyholder a notice of transfer by first-class mail, addressed to
1267 the policyholder's last-known address or to the address to which
1268 premium notices or other policy documents are sent or, with respect to

1269 home service business, by personal delivery with acknowledged receipt.
1270 A notice of transfer shall also be sent to the transferring insurer's agents
1271 or brokers of record on the affected policies.

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

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

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

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

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

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

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

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

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

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

1294 (i) Ratings for the previous five years, if available, or for such lesser
1295 period as is available from two nationally recognized insurance rating
1296 services acceptable to the commissioner, including the rating service's

1297 explanation of the meaning of the ratings. If ratings are unavailable for
1298 any year of the five-year period, the following shall additionally be
1299 disclosed;

1300 (ii) A balance sheet as of December thirty-first for the previous three
1301 years, if available, or for such lesser period as is available and as of the
1302 date of the most recent quarterly statement;

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

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

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

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

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

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

1326 (2) Any licensed foreign insurer that enters into an assumption

1327 reinsurance agreement that transfers the obligations or risks, or both, on
1328 contracts of insurance issued to or owned by residents of this state shall
1329 file or cause to be filed with the commissioner of insurance of this state
1330 the assumption certificate, a copy of the notice of transfer and an
1331 affidavit that the transaction is subject to substantially similar
1332 requirements in the state of domicile of both the transferring and
1333 assuming insurer. If no such requirements exist in the domicile of either
1334 the transferring or assuming insurers, the requirements of subdivision
1335 (3) of subsection (d) of this section shall apply.

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

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

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

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

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

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

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

1359 (e) (1) Policyholders shall have the right to reject the transfer and
1360 novation of their contracts of insurance. Policyholders electing to reject
1361 the assumption transaction shall return to the transferring insurer the
1362 pre-addressed, postage-paid response card or other written notice and
1363 indicate thereon that the assumption is rejected (collectively referred to
1364 as the "Response Card").

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

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

1390 periods shall be measured from the date of delivery of the notice of
1391 transfer pursuant to subdivision (1) of subsection (c) of this section.

1392 (4) The transferring insurer shall be deemed to have received the
1393 response card on the date it is postmarked. A policyholder may also
1394 send its response card by facsimile or other electronic transmission or
1395 by registered mail, express delivery or courier service, in which case the
1396 response card shall be deemed to have been received by the assuming
1397 insurer on the date of actual receipt by the transferring insurer.

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

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2026</i>	38a-26
Sec. 2	<i>October 1, 2026</i>	38a-774
Sec. 3	<i>October 1, 2026</i>	51-344b
Sec. 4	<i>October 1, 2026</i>	19a-7j(b)(5)
Sec. 5	<i>October 1, 2026</i>	38a-48
Sec. 6	<i>from passage</i>	38a-307a
Sec. 7	<i>January 1, 2027</i>	38a-323(b)
Sec. 8	<i>January 1, 2029</i>	38a-323(b)(4)
Sec. 9	<i>from passage</i>	38a-353(a)
Sec. 10	<i>October 1, 2026</i>	38a-356
Sec. 11	<i>October 1, 2026</i>	38a-465d
Sec. 12	<i>January 1, 2027</i>	38a-477jj
Sec. 13	<i>July 1, 2026</i>	38a-591g(e)(4)
Sec. 14	<i>July 1, 2026</i>	38a-591g(i)
Sec. 15	<i>October 1, 2026</i>	38a-708
Sec. 16	<i>October 1, 2026</i>	38a-720a
Sec. 17	<i>October 1, 2026</i>	38a-720e
Sec. 18	<i>October 1, 2026</i>	38a-792(b)
Sec. 19	<i>October 1, 2026</i>	38a-837
Sec. 20	<i>October 1, 2026</i>	38a-838
Sec. 21	<i>October 1, 2026</i>	38a-841
Sec. 22	<i>October 1, 2026</i>	38a-860(a)
Sec. 23	<i>October 1, 2026</i>	New section
Sec. 24	<i>October 1, 2026</i>	Repealer section

INS *Joint Favorable Subst.*