



General Assembly

Amendment

February Session, 2026

LCO No. 4884



Offered by:
REP. WOOD K., 29th Dist.

To: Subst. House Bill No. 5373

File No. 241

Cal. No. 197

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

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

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 Section 38a-26 of the general statutes is repealed and the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

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

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

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

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

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

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

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

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

45 commissioner may base a decision.

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

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

75 [(c)] (d) Any person aggrieved by the action of the commissioner in
76 revoking, suspending or refusing to grant or reissue a license or in
77 imposing a fine may appeal therefrom in accordance with the provisions

78 of section 4-183, except venue for such appeal shall be in the judicial
79 district of New Britain. Appeals under this section shall be privileged in
80 respect to the order of trial assignment.

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

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

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

109 (5) (A) Not later than December first, annually, the Insurance

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

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

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

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

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

146 (b) On or before ~~July thirty-first~~ September fifteenth, annually, the
147 Insurance Commissioner shall render to each domestic insurance
148 company or other domestic entity liable for payment under section 38a-
149 47:

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

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

167 (3) The proposed assessment against that company or entity,
168 calculated in accordance with the provisions of subsection (c) of this
169 section, provided for the purposes of this calculation the amount
170 appropriated to the Insurance Department, the Office of the Healthcare
171 Advocate, the Office of the Behavioral Health Advocate and the Office
172 of Health Strategy from the Insurance Fund plus the cost of fringe
173 benefits for department and office personnel and the estimated
174 expenditures on behalf of the department and said offices from the

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

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

202 (2) When the amount any such company or entity is assessed
203 pursuant to this section exceeds twenty-five per cent of the actual
204 expenditures of the Insurance Department, the Office of the Healthcare
205 Advocate, the Office of the Behavioral Health Advocate and the Office
206 of Health Strategy from the Insurance Fund, such excess amount shall
207 not be paid by such company or entity but rather shall be assessed

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

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

229 (e) On or before [~~September~~] October first, annually, for each fiscal
230 year, the Insurance Commissioner, after receiving any objections to the
231 proposed assessments and making such adjustments as in the
232 commissioner's opinion may be indicated, shall assess each such
233 domestic insurance company or other domestic entity an amount equal
234 to its proposed assessment as so adjusted. Each domestic insurance
235 company or other domestic entity shall pay to the Insurance
236 Commissioner (1) on or before June thirtieth, annually, an estimated
237 payment against its assessment for the following year equal to [~~twenty-~~
238 ~~five~~] thirty-five per cent of its assessment for the fiscal year ending such
239 June thirtieth, (2) on or before [~~September thirtieth~~] October thirty-first,
240 annually, twenty-five per cent of its assessment adjusted to reflect any

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

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

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

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

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

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

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

303 (b) (1) A premium billing notice for any policy subject to the
304 requirements of sections 38a-663 to 38a-696, inclusive, except a workers'

305 compensation policy, shall be mailed or delivered to the insured by the
306 insurer or its agent or, if agreed between the insurer and the named
307 insured, by electronic means, not less than thirty days in advance of the
308 policy's renewal or anniversary date, except that such notice shall not be
309 required for a commercial risk policy if the premium for the ensuing
310 policy period is to increase less than ten per cent on an annual basis. The
311 premium billing notice shall be based on the rates and rules applicable
312 to the ensuing policy period and shall include a notice of transfer when
313 the policy has been transferred from an insurer to an affiliate of such
314 insurer pursuant to the provisions of subparagraph (C) of subdivision
315 (1) of subsection (a) of this section. The provisions of this subsection
316 shall apply to any such policy for which the annual premium was less
317 than fifty thousand dollars for the preceding annual policy period.

318 (2) For purposes of any commercial risk policy subject to the
319 requirements of sections 38a-663 to 38a-696, inclusive, except a workers'
320 compensation policy, the mailing or delivery of a premium billing notice
321 by an insurer's managing general agent, in accordance with the
322 provisions of subdivision (1) of this subsection, including by electronic
323 means, shall constitute compliance by such insurer with said
324 subdivision.

325 (3) For a policy providing personal risk insurance, as defined in
326 section 38a-663, the premium billing notice required pursuant to this
327 subsection shall (A) state that the insurer shall provide a reasonable
328 explanation for premium increases not later than twenty business days
329 after the named insured requests, in writing or by other means of
330 communication, as prescribed by the commissioner, information
331 identifying the reasons for any such premium increase, and (B) include
332 a prominent statement in a location and format prescribed by the
333 commissioner, that includes contact information of such insurer to
334 which such request may be submitted. Any insurer who receives such a
335 request for a reasonable explanation for a premium increase shall
336 provide such reasonable explanation to the insured not later than
337 twenty business days after the date such request is received by such

338 insurer. As used in this subdivision, "reasonable explanation" means
339 sufficient information, in terms that are understandable to an average
340 policyholder that enables the policyholder to determine the basic nature
341 of any premium increase.

342 Sec. 8. Subsection (a) of section 38a-353 of the general statutes is
343 repealed and the following is substituted in lieu thereof (*Effective from*
344 *passage*):

345 (a) Whenever any damaged motor vehicle covered under an
346 automobile insurance policy has been declared to be a constructive total
347 loss by the insurer, the insurer shall, in calculating the value of such
348 vehicle for purposes of determining the settlement amount to be paid to
349 the claimant, use at least the average of the retail values given such
350 vehicle by (1) the [National Automobile Dealers Association] J.D. Power
351 used car guide or its successor, or any other publicly available
352 automobile industry source that has been approved for such use by the
353 Insurance Commissioner, and (2) one other automobile industry source
354 that has been approved for such use by said commissioner. For the
355 purposes of this section, "constructive total loss" means the cost to repair
356 or salvage damaged property, or the cost to both repair and salvage such
357 property, equals or exceeds the total value of the property at the time of
358 loss.

359 Sec. 9. Section 38a-356 of the general statutes is repealed and the
360 following is substituted in lieu thereof (*Effective October 1, 2026*):

361 (a) Any authorized employee of the Department of Emergency
362 Services and Public Protection, Department of Motor Vehicles or a local
363 police department may in writing request any insurance company to
364 release to such employee information relative to any investigation it has
365 made concerning a motor vehicle's loss or potential loss or any
366 information relating to fraud or potential fraud in any claim under a
367 motor vehicle insurance policy. Any insurance company, on its own
368 initiative, may provide and disclose information relating to fraud or
369 potential fraud to such authorized persons. Such information shall

370 include, but not be limited to: (1) An insurance policy relative to such
371 loss, (2) policy premium records, (3) history of previous claims, and (4)
372 other relevant material relating to such loss or potential loss or to such
373 fraud or potential fraud.

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

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

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

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

397 Sec. 10. Section 38a-465d of the general statutes is repealed and the
398 following is substituted in lieu thereof (*Effective October 1, 2026*):

399 [(a) On or before March first of each year, each provider shall file with
400 the commissioner an annual statement containing such information as

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

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

421 [(c)] (a) Except as otherwise required or permitted by law, no person,
422 including, but not limited to, a provider, broker, insurance company,
423 insurance producer, information bureau, rating agency or company, or
424 any other person with actual knowledge of an insured's identity, shall
425 disclose such identity or information where there is a reasonable basis
426 to conclude such information could be used to identify the insured or
427 the insured's financial or medical information to any other person unless
428 such disclosure: (1) Is necessary to effect a life settlement contract
429 between the owner and a provider and the owner and insured have
430 provided prior written consent to such disclosure; (2) is provided in
431 response to an investigation or examination by the commissioner or any
432 other governmental office or agency or pursuant to the requirements of
433 section 38a-465i; (3) is necessary to effectuate the sale of life settlement

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

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

456 Sec. 11. Section 38a-477jj of the general statutes is repealed and the
457 following is substituted in lieu thereof (*Effective January 1, 2027*):

458 (a) For the purposes of this section:

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

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

462 (3) "Health benefit plan" has the same meaning as provided in section
463 38a-1080, except that such term shall not include a grandfathered health
464 plan as such term is used in the Affordable Care Act;

465 (4) "Health care provider" has the same meaning as provided in
466 section 38a-477aa;

467 [(4)] (5) "Health carrier" has the same meaning as provided in section
468 38a-1080;

469 [(5)] (6) "Office of Health Strategy" means the Office of Health
470 Strategy established under section 19a-754a; and

471 [(6)] (7) "Qualified health plan" has the same meaning as provided in
472 section 38a-1080.

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

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

480 (2) Move a prescription drug from a cost-sharing tier that imposes a
481 lesser coinsurance, copayment or deductible for the prescription drug to
482 a cost-sharing tier that imposes a greater coinsurance, copayment or
483 deductible for the prescription drug during a plan year, unless the
484 prescription drug is subject to an in-network coinsurance, copayment or
485 deductible that is not greater than forty dollars per prescription per
486 month in any tier.

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

490 (1) Remove a prescription drug from the drug formulary or list of
491 covered drugs, upon at least ninety days' advance notice to a covered
492 person and the covered person's [treating physician] prescribing health
493 care provider, if:

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

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

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

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

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

515 (d) A health carrier offering a health benefit plan in this state on or
516 after January 1, 2027, that includes a pharmacy benefit and uses a drug
517 formulary or list of covered drugs shall annually, in advance of the
518 applicable open enrollment period for such plan, make available for
519 review by any person, in a readily accessible format, a list of any
520 prescription drugs that are being removed from the formulary and a list
521 of covered drugs effective for the new plan year.

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

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

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

538 Sec. 12. Subdivision (4) of subsection (e) of section 38a-591g of the
539 general statutes is repealed and the following is substituted in lieu
540 thereof (*Effective July 1, 2026*):

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

551 (B) If the external review or the expedited external review is accepted,
552 the health carrier shall notify the commissioner, the assigned
553 independent review organization, the covered person and, if applicable,
554 the covered person's authorized representative in writing of the
555 request's eligibility and acceptance for external review or expedited
556 external review. For an external review, the health carrier shall include

557 in such notice (i) a statement that the covered person or the covered
558 person's authorized representative may submit, not later than five
559 business days after the covered person or the covered person's
560 authorized representative, as applicable, received such notice,
561 additional information in writing to the assigned independent review
562 organization that such organization shall consider when conducting the
563 external review, and (ii) where and how such additional information is
564 to be submitted. If additional information is submitted later than five
565 business days after the covered person or the covered person's
566 authorized representative, as applicable, received such notice, the
567 independent review organization may, but shall not be required to,
568 accept and consider such additional information.

569 (C) If the request:

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

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

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

583 (E) Notwithstanding a health carrier's initial determination that a
584 request for an external review or an expedited external review is
585 ineligible for review, the commissioner may determine, pursuant to the
586 terms of the covered person's health benefit plan, that such request is
587 eligible for such review and assign an independent review organization

588 to conduct such review. Any such review shall be conducted in
589 accordance with this section.

590 Sec. 13. Subsection (i) of section 38a-591g of the general statutes is
591 repealed and the following is substituted in lieu thereof (*Effective July 1,*
592 *2026*):

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

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

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

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

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

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

635 (2) Such notice shall include:

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

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

641 (C) The date the review was conducted;

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

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

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

647 (G) Reference to the evidence or documentation, including any

648 evidence-based standards, considered by the organization in reaching
649 its decision; and

650 (H) For a review involving a determination that the recommended or
651 requested health care service or treatment is experimental or
652 investigational:

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

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

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

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

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

668 (3) Upon the receipt of a notice of the independent review
669 organization's decision to reverse or revise an adverse determination or
670 a final adverse determination, the health carrier shall immediately
671 approve the coverage that was the subject of the adverse determination
672 or the final adverse determination.

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

675 Upon the request of the Insurance Commissioner, any insurance
676 company shall furnish to the Insurance Department the facts relative to

677 the termination of an agent's appointment and the causes thereof. If a
678 company terminates an agent's appointment for cause, such termination
679 shall be reported to the commissioner not later than thirty calendar days
680 after such termination. No agent shall have a cause of action against any
681 insurance company as a result of such company's having furnished to
682 said department pursuant to this section any statement, oral or written,
683 unless such statement is false and was known by such company to be
684 false when made.

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

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

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

708 (2) Nothing in this section shall authorize the commissioner to

709 regulate a self-insured health plan subject to the Employee Retirement
710 Income Security Act of 1974. The commissioner is authorized to regulate
711 those activities an insurer undertakes for the administration of a self-
712 insured health plan that do not relate to the health benefit plan and that
713 comport with the commissioner's statutory authority to regulate
714 insurance and the business of insurance as provided for in 29 USC 1144,
715 as amended from time to time.

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

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

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

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

735 (3) A provision requiring the third-party administrator to render an
736 accounting, on such frequency as the parties agree, that details all
737 transactions performed by the third-party administrator pertaining to
738 the business underwritten by the insurer or the business of the person
739 utilizing the services of the third-party administrator;

740 (4) The procedures for any withdrawals to be made by the third-party
741 administrator from the fiduciary account established under section 38a-
742 720f. Such procedures shall address, but not be limited to: (A)
743 Remittance to an insurer or other person utilizing the services of the
744 third-party administrator who is entitled to remittance, (B) deposit in an
745 account maintained in the name of the insurer or other person utilizing
746 the services of the third-party administrator, (C) transfer to and deposit
747 in a claims-paying account, with claims to be paid as provided for in
748 subsection (d) of section 38a-720f, (D) payment to a group policyholder
749 for remittance to the insurer or other person utilizing the services of the
750 third-party administrator entitled to such remittance, (E) payment to the
751 third-party administrator for its commissions, fees or charges, and (F)
752 remittance of return premiums to the person or persons entitled to such
753 return premiums;

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

756 (6) A termination provision, by which either party to the written
757 agreement may terminate such agreement for cause, that includes a
758 procedure to resolve any disputes regarding the cause for termination
759 of such agreement; and

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

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

772 administrator and the insurer or other person utilizing the services of
773 the third-party administrator.

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

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

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

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

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

802 (b) The commissioner may prescribe reasonable regulations, in

803 accordance with the provisions of chapter 54, governing the licensing of
804 casualty claims adjusters, [and] the adjustment of casualty claims and
805 the establishment of continuing education requirements for persons
806 licensed as casualty claims adjusters.

807 Sec. 18. Section 38a-837 of the general statutes is repealed and the
808 following is substituted in lieu thereof (*Effective October 1, 2026*):

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

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

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

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

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

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

826 (6) Title insurance;

827 (7) Ocean marine insurance;

828 (8) Any transaction or combination of transactions between a person,
829 including affiliates of such person, and an insurer, including affiliates of
830 such insurer, which involves the transfer of investment or credit risk

831 unaccompanied by transfer of insurance risk;

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

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

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

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

840 (1) "Account" means any one of the three accounts created by section
841 38a-839;

842 (2) "Affiliate" means any affiliate, as defined in section 38a-1, as
843 amended by this act, of an insolvent insurer;

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

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

847 (5) (A) "Covered claim" means an unpaid claim, including, but not
848 limited to, one for unearned premiums, that arises out of and is within
849 the coverage and subject to the applicable limits of an insurance policy
850 to which sections 38a-836 to 38a-853, inclusive, apply, if such insurer
851 becomes an insolvent insurer or such claim was assumed as a direct
852 obligation by an insurer that becomes an insolvent insurer, [where such
853 obligation was assumed through a merger or an acquisition, pursuant
854 to an acquisition of assets and assumption of liabilities or pursuant to
855 an assumption reinsurance transaction,] and (i) the claimant or insured
856 is a resident of this state at the time of the insured event, or (ii) the claim
857 is a first party claim for damage to property with a permanent location
858 in this state. For the purposes of this subparagraph, the residence of a
859 claimant or an insured that is not an individual shall be the state in

860 which such claimant's or insured's principal place of business is located
861 at the time of the insured event. "Covered claim" includes claim
862 obligations arising from the issuance of an insurance policy by a
863 member insurer, which are later allocated, transferred, merged into,
864 novated, assumed by or otherwise made the sole responsibility of
865 another member or nonmember insurer if all the following conditions
866 are satisfied: (I) The original member insurer has no remaining
867 obligations on the policy after the transfer; (II) a final order of
868 liquidation with a finding of insolvency has been entered against the
869 insurer that assumed the member insurer's coverage obligations by a
870 court of competent jurisdiction in the insurer's state of domicile; (III) the
871 claim would have been a covered claim if the claim had remained the
872 responsibility of the original member insurer and the order of
873 liquidation had been entered against the original member insurer, with
874 the same claim submission date and liquidation date; and (IV) in cases
875 where the member insurer's coverage obligations were assumed by a
876 nonmember insurer, the transaction received prior regulatory or judicial
877 approval.

878 (B) "Covered claim" does not include (i) any claim by or for the benefit
879 of any reinsurer, insurer, insurance pool or underwriting association, as
880 subrogation recoveries or otherwise, provided a claim for any such
881 amount, asserted against a person insured under a policy issued by an
882 insurer that has become an insolvent insurer, that, if it were not a claim
883 by or for the benefit of a reinsurer, insurer, insurance pool or
884 underwriting association, would be a "covered claim", may be filed
885 directly with the receiver of the insolvent insurer but in no event shall
886 any such claim be asserted against the insured of such insolvent insurer,
887 (ii) any claim by or on behalf of an individual who is neither a citizen of
888 the United States nor an alien legally resident in the United States at the
889 time of the insured event, or an entity other than an individual whose
890 principal place of business is not in the United States at the time of the
891 insured event, and it arises out of an accident, occurrence, offense, act,
892 error or omission that takes place outside of the United States, or a loss
893 to property normally located outside of the United States or, if a

894 workers' compensation claim, it arises out of employment outside of the
895 United States, (iii) any claim by or on behalf of a person who is not a
896 resident of this state, other than a claim for compensation or any other
897 benefit that arises out of and is within the coverage of a workers'
898 compensation policy, against an insured whose net worth at the time
899 the policy was issued or at any time thereafter exceeded twenty-five
900 million dollars, provided an insured's net worth for purposes of this
901 section and section 38a-844 shall be deemed to include the aggregate net
902 worth of the insured and all of its subsidiaries as calculated on a
903 consolidated basis, (iv) any claim by or on behalf of an affiliate of the
904 insolvent insurer at the time the policy was issued or at the time of the
905 insured event, (v) any claim arising out of a policy issued by an insurer
906 that was not licensed to transact insurance in this state at the time the
907 policy was issued, when it assumed the obligation for the covered claim
908 or when the insured event occurred, unless the assumption of the
909 obligation was effected pursuant to subsection (g) of section 23 of this
910 act, (vi) any amount due under any policy originally issued by a surplus
911 lines carrier, risk retention group, self-insurer or group self-insurer, (vii)
912 any obligation assumed by an insolvent insurer after the
913 commencement of any delinquency proceeding, as defined in section
914 38a-905, involving the insolvent insurer or the original insurer, unless it
915 would have been a covered claim absent such assumption, or (viii) any
916 obligation assumed by an insolvent insurer in a transaction in which the
917 original insurer remains separately liable;

918 (6) "Cybersecurity insurance", for purposes of sections 38a-836 to 38a-
919 853, inclusive, includes first and third-party coverage, in a policy or
920 endorsement, written on a direct, admitted basis for losses and loss
921 mitigation arising out of or relating to data privacy breaches,
922 unauthorized information network security intrusions, computer
923 viruses, ransomware, cyber extortion, identity theft and similar
924 exposures;

925 ~~[(6)]~~ (7) "Insolvent insurer" means an insurer (A) [(i)] licensed to
926 transact insurance in this state at the time the policy was issued, [when

927 it assumed the obligation for the covered claim] or when the insured
928 event occurred, and [(ii)] (B) against which a final order of liquidation
929 with a finding of insolvency has been entered by a court of competent
930 jurisdiction in the insurer's state of domicile; [(B) that is (i) the legal
931 successor of an insurer that was licensed to transact insurance in this
932 state either at the time the policy was issued or when the insured event
933 occurred, by reason of a merger, provided such merger is approved by
934 an insurance regulator having jurisdiction over such merger, and (ii)
935 against which a final order of liquidation with a finding of insolvency
936 has been entered by a court of competent jurisdiction in the insurer's
937 state of domicile; or (C) that (i) succeeds to the policy obligations of an
938 insurer that was licensed to transact insurance in this state either at the
939 time the policy was issued or when the insured event occurred, by
940 reason of a division whereby policies issued by such licensed insurer are
941 allocated to or otherwise become the obligation of a successor insurer,
942 provided such division is approved (I) in a jurisdiction that allows such
943 division, and (II) by an insurance regulator having jurisdiction over such
944 division, and (ii) against which a final order of liquidation with a finding
945 of insolvency has been entered by a court of competent jurisdiction in
946 the succeeding insurer's state of domicile. "Insolvent insurer" shall not
947 be construed to mean any insurer with respect to which an order, decree,
948 judgment or finding of insolvency, whether permanent or temporary in
949 nature, or order of rehabilitation or conservation has been issued by a
950 court of competent jurisdiction prior to October 1, 1971;]

951 [(7)] (8) "Member insurer" means any person who (A) writes any kind
952 of insurance to which sections 38a-836 to 38a-853, inclusive, apply under
953 section 38a-837, as amended by this act, including, but not limited to,
954 the exchange of reciprocal or interinsurance contracts, and (B) is
955 licensed to transact insurance in this state. An insurer shall cease to be a
956 member insurer effective on the day following the termination or
957 expiration of its license to transact the kinds of insurance to which said
958 sections 38a-836 to 38a-853, inclusive, apply, however such insurer shall
959 remain liable as a member insurer for any obligations, including
960 obligations for assessments levied prior to the termination or expiration

961 of the insurer's license and for assessments levied after the termination
962 or expiration which relate to any insurer which became an insolvent
963 insurer prior to the termination or expiration of such insurer's license.
964 In the case of such insurer, the average of its net direct written premium
965 for the five calendar years prior to expiration or termination of its
966 license, whether or not the insurer has net direct written premium in the
967 year preceding such expiration or termination, shall be used as its
968 assessment base for any year following such expiration or termination
969 in which the insurer has no direct written premium;

970 [(8)] (9) "Net direct written premiums" means direct gross premiums
971 written in this state on insurance policies to which sections 38a-836 to
972 38a-853, inclusive, apply, less return premiums thereon and dividends
973 paid or credited to policyholders on such direct business, provided the
974 term "net direct written premiums" shall not include premiums on any
975 contract between insurers or reinsurers;

976 [(9)] (10) "Person" means an individual, corporation, partnership,
977 association, joint stock company, business trust, limited liability
978 company, unincorporated organization, voluntary organization,
979 governmental entity or other legal entity;

980 [(10)] (11) "Residence" means, when used in reference to a
981 corporation, its principal place of business; and

982 [(11)] (12) "United States" has the same meaning as provided in
983 section 38a-1, as amended by this act.

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

986 (a) Said association shall:

987 (1) Be obligated to the extent of the covered claims existing prior to
988 the determination of insolvency or the entry of a final order of
989 liquidation with a finding of insolvency, as applicable, and arising
990 within thirty days after the determination of insolvency or the entry of

991 such order, or before the policy expiration date if less than thirty days
992 after the determination or the entry of such order, or before the insured
993 replaces the policy or causes its cancellation if the insured does so within
994 thirty days after such determination or entry of such order, provided
995 such obligation shall be limited as follows: (A) With respect to covered
996 claims for unearned premiums [, to one-half of the unearned premium
997 on any policy,] subject to a maximum of [two] fifty thousand dollars per
998 policy; (B) with respect to covered claims other than for unearned
999 premiums and claims specified in subparagraph (C) or (D) of this
1000 subdivision, such obligation shall include only that amount of each such
1001 claim that [is in excess of one hundred dollars and] is less than or equal
1002 to (i) three hundred thousand dollars for claims arising under policies
1003 of insurers determined to be insolvent prior to October 1, 2007, (ii) four
1004 hundred thousand dollars for claims arising under policies of insurers
1005 determined to be insolvent on or after October 1, 2007, and prior to
1006 October 1, 2015, and (iii) five hundred thousand dollars for claims
1007 arising under policies of insurers against which a final order of
1008 liquidation with a finding of insolvency has been entered by a court of
1009 competent jurisdiction in the insurer's state of domicile on or after
1010 October 1, 2015; (C) with respect to first-party real property claims
1011 arising under policies of insurers determined to be insolvent on or after
1012 June 1, 2026, an amount not exceeding one million dollars for claims
1013 arising from a single occurrence under a policy covering commercial or
1014 residential property; and (D) in no event shall the association be
1015 obligated to pay an amount in excess of five hundred thousand dollars
1016 for all first and third-party claims under a policy or endorsement
1017 providing, or that is found to provide, cybersecurity insurance coverage
1018 and arising out of or related to a single insured event, regardless of the
1019 number of claims made or the number of claimants. Said association
1020 shall pay the full amount of any such claim arising out of a workers'
1021 compensation policy, provided in no event shall said association be
1022 obligated [(I)] (i) to any claimant in an amount in excess of the obligation
1023 of the insolvent insurer under the policy form or coverage from which
1024 the claim arises, or [(II)] (ii) for any claim filed with the association after
1025 the expiration of two years from the date of the declaration of insolvency

1026 unless such claim arose out of a workers' compensation policy and was
1027 timely filed in accordance with section 31-294c;

1028 (2) Be deemed the insurer to the extent of its obligations on the
1029 covered claims and to such extent shall have all rights, duties, and
1030 obligations of the insolvent insurer as if the insurer had not become
1031 insolvent, including, but not limited to, the right to pursue and retain
1032 salvage and subrogation recoverable on covered claim obligations to the
1033 extent paid by the association, provided the association shall not be
1034 deemed the insolvent insurer for the purpose of conferring jurisdiction;

1035 (3) Allocate claims paid and expenses incurred among the three
1036 accounts, created by section 38a-839, separately, and assess member
1037 insurers separately (A) in respect of each such account for such amounts
1038 as shall be necessary to pay the obligations of said association under
1039 subdivision (1) of this subsection subsequent to an insolvency; (B) the
1040 expenses of handling covered claims subsequent to an insolvency; (C)
1041 the cost of examinations under section 38a-846; and (D) such other
1042 expenses as are authorized by sections 38a-836 to 38a-853, inclusive. The
1043 assessments of each member insurer shall be in the proportion that the
1044 net direct written premiums of such member insurer for the calendar
1045 year preceding the assessment on the kinds of insurance in such account
1046 bears to the net direct written premiums of all member insurers for the
1047 calendar year preceding the assessment on the kinds of insurance in
1048 such account. Each member insurer shall be notified of its assessment
1049 not later than thirty days before it is due. No member insurer may be
1050 assessed in any year on any account an amount greater than two per
1051 cent of that member insurer's net direct written premiums for the
1052 calendar year preceding the assessment on the kinds of insurance in said
1053 account, provided if, at the time an assessment is levied on the all other
1054 insurance account, as defined in subdivision (3) of section 38a-839, the
1055 board of directors finds that at least fifty per cent of the total net direct
1056 written premiums of a member insurer and all its affiliates, for the year
1057 on which such assessment is based, were from policies issued or
1058 delivered in Connecticut, on risks located in this state, such member

1059 insurer shall be assessed only on such member insurer's net direct
1060 written premium that is attributable to the kind of insurance that gives
1061 rise to each covered claim. If the maximum assessment, together with
1062 the other assets of said association in any account, does not provide in
1063 any one year in any account an amount sufficient to make all necessary
1064 payments from that account, the funds available may be prorated and
1065 the unpaid portion shall be paid as soon thereafter as funds become
1066 available. Said association may defer, in whole or in part, the assessment
1067 of any member insurer if the assessment would cause the member
1068 insurer's financial statement to reflect amounts of capital or surplus less
1069 than the minimum amounts required for a certificate of authority by any
1070 jurisdiction in which the member insurer is authorized to transact
1071 insurance, provided during the period of deferment, no dividends shall
1072 be paid to shareholders or policyholders. Deferred assessments shall be
1073 paid when such payment will not reduce capital or surplus below the
1074 minimum amounts required for a certificate of authority. Such
1075 payments shall be refunded to those insurers receiving greater
1076 assessments because of such deferment or, at the election of the insurer,
1077 be credited against future assessments. Each member insurer serving as
1078 a servicing facility may set off against any assessment, authorized
1079 payments made on covered claims and expenses incurred in the
1080 payment of such claims by such member insurer if they are chargeable
1081 to the account in respect of which the assessment is made;

1082 (4) Investigate claims brought against said association and adjust,
1083 compromise, settle, and pay covered claims to the extent of said
1084 association's obligations and deny all other claims. The association shall
1085 pay claims in any order it deems reasonable including, but not limited
1086 to, payment in the order of receipt or by classification. It may review
1087 settlements, releases and judgments to which the insolvent insurer or its
1088 insureds were parties to determine the extent to which such settlements,
1089 releases and judgments may be properly contested;

1090 (5) Notify such persons as the commissioner may direct under
1091 subdivision (1) of subsection (b) of section 38a-843;

1092 (6) Handle claims through its employees or through one or more
1093 insurers or other persons designated by said association as servicing
1094 facilities, provided such designation of a servicing facility is approved
1095 by the commissioner and may be declined by a member insurer;

1096 (7) Reimburse each such servicing facility for obligations of said
1097 association paid by such facility and for expenses incurred by such
1098 facility while handling claims on behalf of said association and shall pay
1099 such other expenses of said association as are authorized by sections
1100 38a-836 to 38a-853, inclusive.

1101 (b) Said association may: (1) Employ or retain such persons as are
1102 necessary to handle claims and perform other duties of said association
1103 and shall have the right to appoint and direct legal counsel retained
1104 under liability insurance policies for the defense of covered claims and
1105 to appoint and direct other service providers for covered services; (2)
1106 borrow such funds as may be necessary from time to time to effect the
1107 purposes of sections 38a-836 to 38a-853, inclusive, in accord with the
1108 plan of operation under section 38a-842; (3) sue or be sued; (4) intervene
1109 as a matter of right as a party in any proceeding before any court in this
1110 state that has jurisdiction over an insolvent insurer, as defined in section
1111 38a-838, as amended by this act; (5) negotiate and become a party to such
1112 contracts as are necessary to carry out the purpose of sections 38a-836 to
1113 38a-853, inclusive; (6) perform such other acts as are necessary or proper
1114 to effectuate the purpose of said sections; (7) refund to the member
1115 insurers in proportion to the contribution of each such member insurer
1116 to that account, that amount by which the assets of the account exceed
1117 the liabilities, if, at the end of any calendar year, the board of directors
1118 finds that the assets of said association in any account exceed the
1119 liabilities of that account as estimated by the board of directors for the
1120 coming year.

1121 (c) (1) Each insurer paying an assessment under sections 38a-836 to
1122 38a-853, inclusive, may offset one hundred per cent of the amount of
1123 such assessment against its premium tax liability to this state under
1124 chapter 207. Such offset shall be taken over a period of the five

1125 successive tax years following the year of payment of the assessment, at
1126 the rate of twenty per cent per year of the assessment paid to the
1127 association. Each insurer to which has been refunded by the association,
1128 pursuant to subsection (b) of this section, all or a portion of an
1129 assessment previously paid to the association by the insurer shall be
1130 required to pay to the Department of Revenue Services an amount equal
1131 to the total amount that has been claimed as an offset against the
1132 premiums tax liability on the premiums tax return or returns, as the case
1133 may be, filed by such insurer and that is attributable to such refunded
1134 assessment, provided the amount required to be paid to said
1135 department shall not exceed the amount of the refunded assessment. If
1136 the amount of the refunded assessment exceeds the total amount that
1137 has been claimed as an offset against the premiums tax liability on the
1138 premiums tax return or returns filed by such insurer and that is
1139 attributable to such refunded assessment, such excess may not be
1140 claimed as an offset against the premiums tax liability on a premiums
1141 tax return or returns filed by such insurer or, if the offset has been
1142 transferred to another person pursuant to subdivision (2) of this
1143 subsection, by such other person. For purposes of this subparagraph, if
1144 the offset has been transferred to another person pursuant to
1145 subdivision (2) of this subsection, the total amount that has been claimed
1146 as an offset against the premiums tax liability on the premiums tax
1147 return or returns filed by such insurer includes the total amount that has
1148 been claimed as an offset against the premiums tax liability on the
1149 premiums tax return or returns filed by such other person. The
1150 association shall promptly notify the Commissioner of Revenue Services
1151 of the name and address of the insurers to which such refunds have been
1152 made, the amount of such refunds and the date on which such refunds
1153 were mailed to such insurer. If the amount that an insurer is required to
1154 pay to the Department of Revenue Services has not been so paid on or
1155 before the forty-fifth day after the date of mailing of such refunds, the
1156 insurer shall be liable for interest on such amount at the rate of one per
1157 cent per month or fraction thereof from such forty-fifth day to the date
1158 of payment.

1159 (2) An insurer, in this subparagraph called "the transferor", may
1160 transfer any offset provided under subdivision (1) of this subsection to
1161 an affiliate, as defined in section 38a-1, as amended by this act, of the
1162 transferor. Any such transfer of the offset by the transferor and any
1163 subsequent transfer or transfers of the same offset shall not affect the
1164 obligation of the transferor to pay to the Department of Revenue
1165 Services any sums which are acquired by refund from the association
1166 pursuant to subsection (b) of this section and which are required to be
1167 paid to the Department of Revenue Services pursuant to subdivision (1)
1168 of this subsection. Such offset may be taken by any transferee only
1169 against the transferee's premium tax liability to this state under chapter
1170 207. The Commissioner of Revenue Services shall not allow such offset
1171 to a transferee against its premium tax liability unless the transferor, the
1172 affiliate to which the offset was originally transferred, each subsequent
1173 transferor and each subsequent transferee have filed such information
1174 as may be required on forms provided by said commissioner with
1175 respect to any such transfer or transfers on or before the due date of the
1176 premium tax return on which such offset would have been taken by the
1177 transferor if no transfer had been made by the transferor.

1178 Sec. 21. Subsection (a) of section 38a-860 of the general statutes is
1179 repealed and the following is substituted in lieu thereof (*Effective October*
1180 *1, 2026*):

1181 (a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for
1182 the policies and contracts specified in subsection (f) of this section: (1)
1183 To any person, except for a nonresident certificate holder under a group
1184 policy or contract, who is the beneficiary, assignee or payee, including a
1185 health care provider rendering services covered under a health
1186 insurance policy or certificate, of the person covered under subdivision
1187 (2) of this subsection, regardless of where the person resides, and (2) any
1188 person who is the owner of, or certificate holder or enrollee under, such
1189 policy or contract, other than an unallocated annuity contract or a
1190 structured settlement annuity, and in each case who (A) is a resident, or
1191 (B) is not a resident, provided (i) the member insurer that issued such

1192 policy or contract is domiciled in this state, (ii) the state in which the
1193 person resides has an association similar to the association created by
1194 this section and sections 38a-837, 38a-838, as amended by this act, 38a-
1195 845, 38a-853, 38a-859, 38a-862, 38a-863, 38a-865, and 38a-866, and (iii) the
1196 person is not eligible for coverage by an association in any other state
1197 because the insurer was not licensed in the state in which the person
1198 resides at the time specified in the state's guaranty association law,
1199 unless the assumption of the obligation was effected pursuant to
1200 subsection (g) of section 23 of this act.

1201 Sec. 22. Section 38a-1 of the general statutes is repealed and the
1202 following is substituted in lieu thereof (*Effective October 1, 2026*):

1203 Terms used in this title and section 23 of this act, unless it appears
1204 from the context to the contrary, shall have a scope and meaning as set
1205 forth in this section.

1206 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly
1207 through one or more intermediaries, controls, is controlled by or is
1208 under common control with another person.

1209 (2) "Alien insurer" means any insurer that has been chartered by or
1210 organized or constituted within or under the laws of any jurisdiction or
1211 country without the United States.

1212 (3) "Annuities" means all agreements to make periodical payments
1213 where the making or continuance of all or some of the series of the
1214 payments, or the amount of the payment, is dependent upon the
1215 continuance of human life or is for a specified term of years. This
1216 definition does not apply to payments made under a policy of life
1217 insurance.

1218 (4) "Commissioner" means the Insurance Commissioner.

1219 (5) "Control", "controlled by" or "under common control with" means
1220 the possession, direct or indirect, of the power to direct or cause the
1221 direction of the management and policies of a person, whether through

1222 the ownership of voting securities, by contract other than a commercial
1223 contract for goods or nonmanagement services, or otherwise, unless the
1224 power is the result of an official position with the person.

1225 (6) "Domestic insurer" means any insurer that has been chartered by,
1226 incorporated, organized or constituted within or under the laws of this
1227 state.

1228 (7) "Domestic surplus lines insurer" means any domestic insurer that
1229 has been authorized by the commissioner to write surplus lines
1230 insurance.

1231 (8) "Foreign country" means any jurisdiction not in any state, district
1232 or territory of the United States.

1233 (9) "Foreign insurer" means any insurer that has been chartered by or
1234 organized or constituted within or under the laws of another state or a
1235 territory of the United States.

1236 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
1237 unable to pay its obligations when they are due, or when its admitted
1238 assets do not exceed its liabilities plus the greater of: (A) Capital and
1239 surplus required by law for its organization and continued operation;
1240 or (B) the total par or stated value of its authorized and issued capital
1241 stock. For purposes of this subdivision "liabilities" shall include but not
1242 be limited to reserves required by statute or by regulations adopted by
1243 the commissioner in accordance with the provisions of chapter 54 or
1244 specific requirements imposed by the commissioner upon a subject
1245 company at the time of admission or subsequent thereto.

1246 (11) "Insurance" means any agreement to pay a sum of money,
1247 provide services or any other thing of value on the happening of a
1248 particular event or contingency or to provide indemnity for loss in
1249 respect to a specified subject by specified perils in return for a
1250 consideration. In any contract of insurance, an insured shall have an
1251 interest which is subject to a risk of loss through destruction or
1252 impairment of that interest, which risk is assumed by the insurer and

1253 such assumption shall be part of a general scheme to distribute losses
1254 among a large group of persons bearing similar risks in return for a
1255 ratable contribution or other consideration.

1256 (12) "Insurer" or "insurance company" includes any person or
1257 combination of persons doing any kind or form of insurance business
1258 other than a fraternal benefit society, and shall include a receiver of any
1259 insurer when the context reasonably permits.

1260 (13) "Insured" means a person to whom or for whose benefit an
1261 insurer makes a promise in an insurance policy. The term includes
1262 policyholders, subscribers, members and beneficiaries. This definition
1263 applies only to the provisions of this title and does not define the
1264 meaning of this word as used in insurance policies or certificates.

1265 (14) "Life insurance" means insurance on human lives and insurances
1266 pertaining to or connected with human life. The business of life
1267 insurance includes granting endowment benefits, granting additional
1268 benefits in the event of death by accident or accidental means, granting
1269 additional benefits in the event of the total and permanent disability of
1270 the insured, and providing optional methods of settlement of proceeds.
1271 Life insurance includes burial contracts to the extent provided by
1272 section 38a-464.

1273 (15) "Mutual insurer" means any insurer without capital stock, the
1274 managing directors or officers of which are elected by its members.

1275 (16) "Person" means an individual, a corporation, a partnership, a
1276 limited liability company, an association, a joint stock company, a
1277 business trust, an unincorporated organization or other legal entity.

1278 (17) "Policy" means any document, including attached endorsements
1279 and riders, purporting to be an enforceable contract, which
1280 memorializes in writing some or all of the terms of an insurance
1281 contract.

1282 (18) "State" means any state, district, or territory of the United States.

1283 (19) "Subsidiary" of a specified person means an affiliate controlled
1284 by the person directly, or indirectly through one or more intermediaries.

1285 (20) "Unauthorized insurer" or "nonadmitted insurer" means an
1286 insurer that has not been granted a certificate of authority by the
1287 commissioner to transact the business of insurance in this state or an
1288 insurer transacting business not authorized by a valid certificate.

1289 (21) "United States" means the United States of America, its territories
1290 and possessions, the Commonwealth of Puerto Rico and the District of
1291 Columbia.

1292 Sec. 23. (NEW) (*Effective October 1, 2026*) (a) As used in this section:

1293 (1) "Assuming insurer" means any insurer that acquires an insurance
1294 obligation or risk, or both, from any transferring insurer pursuant to an
1295 assumption reinsurance agreement.

1296 (2) "Assumption reinsurance agreement" means any contract that (A)
1297 transfers insurance obligations or risks, or both, of existing or in-force
1298 contracts of insurance from a transferring insurer to an assuming
1299 insurer, and (B) is intended to effect a novation of the transferred
1300 contract of insurance with the result that the assuming insurer becomes
1301 directly liable to the policyholders of the transferring insurer and the
1302 transferring insurer's insurance obligations or risks, or both, under the
1303 contracts are extinguished.

1304 (3) "Home service business" means any insurance business for which
1305 premiums are collected on a weekly or monthly basis by an agent of the
1306 insurer.

1307 (4) "Notice of transfer" means the written notice to policyholders
1308 required pursuant to subsection (c) of this section.

1309 (5) "Policyholder" means any individual or entity that has the right to
1310 terminate or otherwise alter the terms of an insurance agreement.
1311 "Policyholder" includes any certificate holder whose certificate is in

1312 force on the proposed effective date of the assumption, if such certificate
1313 holder has the right to keep such certificate in force without a change in
1314 benefits following termination of the group policy, except that the right
1315 to keep such certificate in force shall not include the right to elect
1316 individual coverage under the Consolidated Omnibus Budget
1317 Reconciliation Act, Section 601, et seq., of the Employee Retirement
1318 Income Security Act of 1974, as amended from time to time.

1319 (6) "Transferring insurer" means any insurer that transfers an
1320 insurance obligation or risk, or both, to any assuming insurer pursuant
1321 to an assumption reinsurance agreement.

1322 (b) (1) The provisions of this section shall apply to any insurer
1323 authorized in the state that assumes or transfers the obligations or risks,
1324 or both, on insurance agreements pursuant to an assumption
1325 reinsurance agreement.

1326 (2) The provisions of this section shall not apply to:

1327 (A) Any reinsurance agreement or transaction in which the
1328 transferring insurer continues to remain directly liable for such insurer's
1329 insurance obligations or risks, or both, under any such insurance
1330 agreement subject to the reinsurance agreement;

1331 (B) The substitution of one insurer for another insurer upon the
1332 expiration of insurance coverage pursuant to statutory or contractual
1333 requirements and the issuance of a new insurance agreement by such
1334 other insurer;

1335 (C) The transfer of insurance agreements pursuant to mergers or
1336 consolidations of two or more insurers to the extent that such mergers
1337 or consolidations are regulated by statute;

1338 (D) Any insurer subject to a judicial order of liquidation or
1339 rehabilitation;

1340 (E) Any reinsurance agreement or transaction to which a state

1341 insurance guaranty association is a party, provided policyholders do not
1342 lose any rights or claims afforded under such policyholders' original
1343 policies pursuant to chapter 704a of the general statutes; or

1344 (F) The transfer of liabilities from one insurer to another insurer
1345 under a group health insurance policy upon the request of the group
1346 policyholder.

1347 (c) (1) The transferring insurer shall provide or cause to be provided
1348 a notice of transfer to (A) (i) each policyholder by first-class mail,
1349 addressed to such policyholder's last-known address or to the address
1350 to which premium notices or other policy documents are sent, or (ii)
1351 with respect to a home service business, such home service business by
1352 personal delivery with acknowledged receipt, and (B) the transferring
1353 insurer's agents or brokers of record on the affected policies.

1354 (2) The notice of transfer shall provide:

1355 (A) The date such transfer and novation of the policyholder's
1356 insurance agreement is proposed to take place;

1357 (B) The name, address and telephone number of the assuming and
1358 transferring insurer;

1359 (C) That the policyholder has the right to consent to or reject the
1360 transfer and novation;

1361 (D) The procedures and time limit for the policyholder to consent to
1362 or reject the transfer and novation;

1363 (E) A summary of any effect that such consent to or rejection of the
1364 transfer and novation will have on the policyholder's rights pursuant to
1365 such insurance agreement;

1366 (F) A statement that the assuming insurer is licensed to write the type
1367 of business being assumed in the state where the policyholder resides,
1368 or is otherwise authorized, pursuant to the provisions of this section, to
1369 assume such type of business;

1370 (G) The name and address of the person at the transferring insurer to
1371 whom the policyholder may send such policyholder's written statement
1372 of consent to or rejection of the transfer and novation;

1373 (H) The address and telephone number of the insurance regulatory
1374 official of the state where the policyholder resides to whom such
1375 policyholder may write or call such official for further information
1376 regarding the financial condition of the assuming insurer; and

1377 (I) The following financial data of the transferring and assuming
1378 insurers:

1379 (i) Insurance ratings for the last five years, if available, or for such
1380 lesser period as is available, from two nationally recognized insurance
1381 rating services approved by the commissioner, including each rating
1382 service's explanation of the meaning of such ratings. If any such ratings
1383 are unavailable for any year of the five-year period, the unavailability of
1384 such ratings shall be disclosed in the notice of transfer;

1385 (ii) A balance sheet as of December thirty-first for the previous three
1386 years, if available, or for such lesser period as is available and as of the
1387 date of the most recent quarterly statement;

1388 (iii) A copy of the management's discussion and analysis filed as a
1389 supplement to the previous year's annual statement; and

1390 (iv) An explanation of the reason for the transfer.

1391 (3) Any such notice of transfer in a form prescribed by the
1392 commissioner pursuant to subsection (h) of this section or a
1393 substantially similar form of notice shall be deemed to comply with the
1394 requirements of subdivision (2) of this subsection.

1395 (4) The notice of transfer shall include a preaddressed, postage
1396 prepaid response card that each policyholder may return as such
1397 policyholder's written statement of acceptance or rejection of the
1398 transfer and novation.

1399 (5) The notice of transfer shall be filed as part of the prior approval
1400 requirement set forth in subdivision (1) of subsection (d) of this section.

1401 (d) (1) Prior approval by the commissioner is required for any
1402 transaction where any insurer domiciled in this state assumes or
1403 transfers obligations or risks, or both, on insurance agreements under
1404 an assumption reinsurance agreement. No insurer licensed in this state
1405 shall transfer obligations or risks, or both, on insurance agreements
1406 issued to or owned by residents of this state to any insurer that is not
1407 licensed in this state. No insurer domiciled in this state shall assume
1408 obligations or risks, or both, on insurance agreements issued to or
1409 owned by policyholders residing in any other state unless such insurer
1410 is licensed in such other state, or the insurance regulatory official of such
1411 other state has approved such assumption reinsurance agreement.

1412 (2) Any licensed foreign insurer that enters into an assumption
1413 reinsurance agreement that transfers the obligations or risks, or both, on
1414 insurance agreements issued to or owned by residents of this state shall
1415 file or cause to be filed with the commissioner the assumption certificate,
1416 a copy of the notice of transfer and an affidavit that the transaction is
1417 subject to substantially similar requirements in the state of domicile of
1418 both the transferring and assuming insurers. If no such requirements
1419 exist in the domicile of either the transferring or assuming insurers, the
1420 requirements of subdivision (3) of this subsection shall apply.

1421 (3) Any licensed foreign insurer that enters into an assumption
1422 reinsurance agreement that transfers the obligations or risks, or both, on
1423 insurance agreements issued to or owned by residents of this state shall
1424 obtain prior approval of the commissioner and be subject to all other
1425 requirements of this section applicable to residents of this state, unless
1426 the transferring and assuming insurers are subject to assumption
1427 reinsurance requirements adopted by state law or regulation in the
1428 jurisdiction of such transferring or assuming insurer's domicile that are
1429 substantially similar to the requirements of this section, as determined
1430 by the commissioner.

1431 (4) The following factors, along with such other factors as the
1432 commissioner deems appropriate shall be considered by the
1433 commissioner in reviewing a request for approval of any such proposed
1434 transfer:

1435 (A) The financial condition of the transferring and assuming insurers
1436 and the effect such proposed transfer will have on the financial
1437 condition of such transferring and assuming insurers;

1438 (B) The competence, experience and integrity of persons who control
1439 the operation of the assuming insurer;

1440 (C) The plans or proposals of the assuming insurer applicable to the
1441 administration of the policies subject to the proposed transfer;

1442 (D) Whether the transfer is fair and reasonable to the policyholders
1443 of the transferring and assuming insurers; and

1444 (E) Whether the notice of proposed transfer is fair, adequate and not
1445 misleading.

1446 (e) (1) Any policyholder shall have the right to reject the transfer and
1447 novation of such policyholder's insurance agreement. Any such
1448 policyholder electing to reject such transfer and novation shall return to
1449 the transferring insurer the preaddressed, postage prepaid response
1450 card, provided pursuant to subdivision (4) of subsection (c) of this
1451 section, or provide other written notice of such rejection, and indicate
1452 on such card or other written notice, as applicable, that such transfer
1453 and novation is rejected by such policyholder.

1454 (2) Payment of any premium to the assuming insurer during the
1455 twenty-four-month period after notice is received shall be deemed to
1456 indicate the policyholder's acceptance of the transfer to the assuming
1457 insurer and a novation shall be deemed to have been effected, provided
1458 the premium notice clearly states that payment of the premium to the
1459 assuming insurer shall constitute acceptance of the transfer. The
1460 premium notice shall also provide a method for the policyholder to pay

1461 the premium while reserving the right to reject the transfer. With respect
1462 to any home service business or any other business not using premium
1463 notices, the disclosures and procedural requirements of this subsection
1464 shall be set forth in the notice of transfer required pursuant to
1465 subsections (c) and (d) of this section and in the assumption certificate.

1466 (3) Not less than twenty-four months after the mailing of the initial
1467 notice of transfer required pursuant to subsection (c) of this section, if
1468 consent to, or rejection of, the transfer and assumption has not been
1469 received or consent has not been deemed to have occurred under
1470 subdivision (2) of this subsection, the transferring company shall send
1471 to the policyholder a second and final notice of transfer as specified in
1472 subsection (c) of this section. If the policyholder does not consent to, or
1473 reject the transfer during the one-month period immediately following
1474 the date on which the transferring insurer mails the second and final
1475 notice of transfer, such policyholder's consent shall be deemed to have
1476 occurred and novation of the insurance agreement will be effected. With
1477 respect to any home service business, or any other business not using
1478 premium notices, the twenty-four and one-month periods shall be
1479 measured from the date of delivery of the notice of transfer pursuant to
1480 subdivision (1) of subsection (c) of this section.

1481 (4) The transferring insurer shall be deemed to have received the
1482 response card on the date it is postmarked, provided if a policyholder
1483 provides such policyholder's response card by facsimile or other
1484 electronic transmission or by registered mail, express delivery or courier
1485 service, such response card shall be deemed to have been received by
1486 the assuming insurer on the date of actual receipt by the transferring
1487 insurer.

1488 (f) If a policyholder consents to the transfer pursuant to subsection (e)
1489 of this section or if the transfer is effected under subsection (g) of this
1490 section, there shall be a novation of the insurance agreement subject to
1491 the assumption reinsurance agreement. A novation pursuant to this
1492 subsection shall result in (1) the transferring insurer being relieved of all
1493 insurance obligations or risks, or both, transferred under the

1494 assumption reinsurance agreement, and (2) the assuming insurer being
1495 directly and solely liable to such policyholder for such insurance
1496 obligations or risks, or both.

1497 (g) If an insurer domiciled in this state or in a jurisdiction having a
1498 substantially similar law is deemed by the domiciliary commissioner to
1499 be in hazardous financial condition, as provided for in section 38a-8-103
1500 of the regulations of Connecticut state agencies, as amended from time
1501 to time, or an administrative proceeding has been instituted against
1502 such insurer for the purpose of reorganizing or conserving such insurer,
1503 and the transfer of the insurance agreements is in the best interest of the
1504 policyholders, as determined by the domiciliary commissioner, a
1505 transfer and novation may be effected notwithstanding the provisions
1506 of this section, including, but not limited to, a form of implied consent
1507 and adequate notification to such policyholders of the circumstances
1508 requiring the transfer as approved by the commissioner.

1509 (h) The commissioner may adopt regulations, in accordance with
1510 chapter 54 of the general statutes, to establish the form of notice of
1511 transfer required in this section.

1512 Sec. 24. Subsection (b) of section 38a-741 of the 2026 supplement to
1513 the general statutes is repealed and the following is substituted in lieu
1514 thereof (*Effective October 1, 2026*):

1515 (b) (1) [When any policy of insurance is procured or renewed under
1516 the authority of such license providing a line of insurance or its
1517 component that does not, on the effective date of coverage, appear on
1518 the current published list, both the licensee and the insured shall first
1519 make a diligent effort, as defined by the commissioner, to procure, from
1520 any authorized insurer or insurers, the full amount of insurance
1521 required to protect the interest of such insured, and further showing (A)
1522 that the amount of insurance procured from an unauthorized insurer or
1523 insurers is only the excess over the amount so procurable from
1524 authorized insurers, (B) the type of policy, and (C) if such policy is for
1525 real property, the location of such property. Such licensee shall keep, in

1526 a form approved by the commissioner, and make available for
1527 examination by the commissioner upon request, all (i) documentation
1528 concerning such licensee's and insured's diligent effort to procure, from
1529 any authorized insurer or insurers, the full amount of insurance
1530 required to protect the interest of such insured, and (ii) information
1531 concerning each policy placed in the surplus lines market.] The
1532 commissioner may require, annually, that each surplus lines broker
1533 licensed pursuant to section 38a-794, and surplus lines insurer
1534 authorized to place surplus lines insurance in this state, submit a report
1535 to the commissioner, in a form and manner prescribed by the
1536 commissioner, that contains the following information applicable to
1537 surplus lines policies issued in this state: (A) The number and types of
1538 policies issued; (B) for any policy covering real property, the location of
1539 such property, and the total premium paid by insureds for coverage
1540 under such policy; and (C) the number of policies renewed in the prior
1541 year. The provisions of this subdivision shall not prevent the
1542 commissioner from requesting and obtaining any such additional
1543 information pursuant to the provisions of this title.

1544 (2) The provisions of subdivision (1) of this subsection shall not apply
1545 to (A) [any such policy providing or including flood insurance,
1546 including] flood insurance procured from the National Flood Insurance
1547 Program, (B) any policy of insurance procured under the authority of
1548 such license for an insured that is an exempt commercial purchaser, as
1549 defined in Section 527 of the Dodd-Frank Wall Street Reform and
1550 Consumer Protection Act, P.L. 111-203, as amended from time to time,
1551 [provided (i) the surplus lines broker has disclosed to such exempt
1552 commercial purchaser that such insurance may or may not be available
1553 from an authorized insurer, that may provide greater protection with
1554 more regulatory oversight, and (ii) such exempt commercial purchaser
1555 has subsequently requested such broker, in writing, to procure such
1556 policy from an unauthorized insurer,] or (C) any policy of insurance
1557 where the broker seeks to procure or place such insurance through an
1558 unaffiliated wholesale surplus lines insurance broker.

1559 Sec. 25. Section 38a-66 of the general statutes is repealed. (*Effective*
 1560 *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>from passage</i>	38a-353(a)
Sec. 9	<i>October 1, 2026</i>	38a-356
Sec. 10	<i>October 1, 2026</i>	38a-465d
Sec. 11	<i>January 1, 2027</i>	38a-477jj
Sec. 12	<i>July 1, 2026</i>	38a-591g(e)(4)
Sec. 13	<i>July 1, 2026</i>	38a-591g(i)
Sec. 14	<i>October 1, 2026</i>	38a-708
Sec. 15	<i>October 1, 2026</i>	38a-720a
Sec. 16	<i>October 1, 2026</i>	38a-720e
Sec. 17	<i>October 1, 2026</i>	38a-792(b)
Sec. 18	<i>October 1, 2026</i>	38a-837
Sec. 19	<i>October 1, 2026</i>	38a-838
Sec. 20	<i>October 1, 2026</i>	38a-841
Sec. 21	<i>October 1, 2026</i>	38a-860(a)
Sec. 22	<i>October 1, 2026</i>	38a-1
Sec. 23	<i>October 1, 2026</i>	New section
Sec. 24	<i>October 1, 2026</i>	38a-741(b)
Sec. 25	<i>October 1, 2026</i>	Repealer section