Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Changes to the Insurance Fund and Health & Welfare Fee Assessments
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Business Office
Drafter	Jane Callanan

Overview

Brief Summary of Proposal

Technical changes to the insurance fund and health & welfare fee assessment processes.

What problem is this proposal looking to solve?

Insurance Fund: Alignment of dates to accommodate timing for receipt of the required report from DRS and adding the Office of Behavioral Health Advocate to the process. Health & Welfare Fee: Alignment of the objection process managed by the Insurance Department to the current process applicable to the Public Health Fee (CGS 19a-7p).

How does the proposal solve the problem?

Insurance Fund: Accommodates date of receipt of DRS tax report. Health & Welfare Fee: Creates consistent and appropriate objection processes for both the Health & Welfare fee and the Public Health fee.

Section by section summary:

Section #(s)	Section Summary
1	Alignment of dates to accommodate timing for receipt of the required report from DRS and adding the Office of Behavioral Health Advocate to the process. The second payment due date for the Insurance Fund assessment will be changed from September 30 to October 31. The first payment has been increased to 35% of the total assessment in order to address the potential cash flow needs during October as suggested by OPM in the past.
2	Alignment the objection process managed by the Insurance Department to the current process applicable to the Public Health Fee (CGS 19a-7p).

Statutory Reference: Sec. 1: 38a-48; Sec. 2: 19a-7j

Background

☒ New Proposal ☐ Resubmission

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☐ Check here if this proposal does NOT impact other agencies

Agency	Dept. of Public Health
Contact	Adam Skowera
Date Contacted	11/12/2025
Status	☒ Approved ☐ Unresolved
Open Issues	N/A
Agency	Dept. of Revenue Services
Contact	Ernie Adamo
Date Contacted	11/12/2025
Status	☒ Approved ☐ Unresolved
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below:

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Sec. 1. Section 38a-48 of the General Statutes is repealed and the following is substituted in lieu thereof. (Effective October 1, 2026)

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

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

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

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

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

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

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

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

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

(e) On or before [September] October first, annually, for each fiscal year, the Insurance Commissioner, after receiving any objections to the proposed assessments and making such adjustments as in the commissioner's opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner (1) on or before June thirtieth, annually, an estimated payment against its assessment for the following year equal to [twenty] thirty-five per cent of its assessment for the fiscal year ending such June thirtieth, (2) on or before [September thirtieth] October thirty-first, annually, twenty-five per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (f) of this section, and (3) on or before the following December thirty-first and March thirty-first, annually, each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner the

remaining [fifty] forty per cent of its proposed assessment to the department in two equal installments.

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

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

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

Sec. 2. Section 19a-7j of the General Statutes is repealed and the following is substituted in lieu thereof. (Effective October 1, 2026)

(a) Not later than September first, annually, the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, shall (1) determine the amount appropriated for the following purposes: (A) To purchase, store and distribute vaccines for routine immunizations included in the schedule for active immunization required by section 19a-7f; (B) to purchase, store and distribute (i) vaccines to prevent hepatitis A and B in persons of all ages, as recommended by the schedule for immunizations published by the National Advisory Committee for Immunization Practices, (ii) antibiotics necessary for the treatment of tuberculosis and biologics and antibiotics necessary for the detection and treatment of tuberculosis infections, and (iii) antibiotics to support treatment of patients in communicable disease control clinics, as defined in section 19a-216a; (C) to administer the immunization program described in section 19a-7f; and (D) to provide services needed to collect up-to-date information on childhood immunizations for all children enrolled in Medicaid who reach two years of age during the year preceding the current fiscal year, to incorporate such information into the immunization information system, established pursuant to section 19a-7h, (2) calculate the difference between the amount expended in the prior fiscal year for the purposes set forth in subdivision (1) of this subsection and the amount of the appropriation used for the purpose of the health and welfare fee established in subparagraph (A) of subdivision (2) of subsection (b) of this section in that same year, and (3) inform the Insurance Commissioner of such amounts.

(b) (1) As used in this subsection, (A) "health insurance" means health insurance of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, and (B) "exempt insurer" means a domestic insurer that administers self-insured health benefit plans and is exempt from third-party administrator licensure under subparagraph (C) of subdivision (11) of section 38a-720 and section 38a-720a.

(2) (A) Each domestic insurer or domestic health care center doing health insurance business in this state shall annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

(B) Each third-party administrator licensed pursuant to section 38a-720a that provides administrative services for self-insured health benefit plans and each exempt insurer shall, on behalf of the self-insured health benefit plans for which such third-party administrator or exempt insurer provides administrative services, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, a health and welfare fee assessed by the Insurance Commissioner pursuant to this section.

(3) Not later than September first, annually, each such insurer, health care center, third-party administrator and exempt insurer shall report to the Insurance Commissioner, on a form designated by said commissioner, the number of insured or enrolled lives in this state as of May first immediately preceding for which such insurer, health care center, third-party administrator or exempt insurer is providing health insurance or administering a self-insured health benefit plan that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Such number shall not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers' compensation insurance or Medicare Part C plans.

(4) Not later than November first, annually, the Insurance Commissioner shall determine the fee to be assessed for the current fiscal year against each such insurer, health care center, third-party administrator and exempt insurer. Such fee shall be calculated by multiplying the number of lives reported to said commissioner pursuant to subdivision (3) of this subsection by a factor, determined annually by said commissioner as set forth in this subdivision, to fully fund the amount determined under subsection (a) of this section, adjusted for a health and welfare fee, by subtracting, if the amount appropriated was more than the amount expended or by adding, if the amount expended was more than the amount appropriated, the amount calculated under subdivision (2) of subsection (a) of this section. The Insurance Commissioner shall determine the factor by dividing the adjusted amount by the total number of lives reported to said commissioner pursuant to subdivision (3) of this subsection.

(5) (A) Not later than December first, annually, the Insurance Commissioner shall submit a statement to each such insurer, health care center, third-party administrator and exempt insurer that includes the proposed fee, identified on such statement as the "Health and Welfare fee", for the insurer, health care center, third-party administrator or exempt insurer calculated in accordance with this subsection. Not later than December twentieth,

annually, any insurer, health care center, third-party administrator or exempt insurer may submit an objection to the Insurance Commissioner concerning the proposed health and welfare fee. The Insurance Commissioner, after making any adjustment that said commissioner deems necessary, shall, not later than January first, annually, submit a final statement to each insurer, health care center, third-party administrator and exempt insurer that includes the final fee for the insurer, health care center, third-party administrator or exempt insurer. Each such insurer and health care center shall pay such fee to the Insurance Commissioner not later than February first, annually. Each such insurer, health care center, third-party administrator and exempt insurer shall pay such fee to the Insurance Commissioner not later than February first, annually.

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

(6) Any insurer, health care center, third-party administrator or exempt insurer that fails to file the report required under subdivision (3) of this subsection shall pay a late filing fee of one hundred dollars per day for each day from the date such report was due. The Insurance Commissioner may require an insurer, health care center, third-party administrator or exempt insurer subject to this subsection to produce the records in its possession, and may require any other person to produce the records in such person's possession, that were used to prepare such report, for said commissioner's or said commissioner's designee's examination. If said commissioner determines there is other than a good faith discrepancy between the actual number of insured or enrolled lives that should have been reported under subdivision (3) of this subsection and the number actually reported, such insurer, health care center, third-party administrator or exempt insurer shall pay a civil penalty of not more than fifteen thousand dollars for each report filed for which said commissioner determines there is such a discrepancy.

(7) (A) The Insurance Commissioner shall apply an overpayment of the health and welfare fee by an insurer, health care center, third-party administrator or exempt insurer for any fiscal year as a credit against the health and welfare fee due from such insurer, health care center, third-party administrator or exempt insurer for the succeeding fiscal year, subject to an adjustment under subdivision (4) of this subsection, if: (i) The amount of the overpayment exceeds five thousand dollars; and (ii) on or before June first of the calendar

year of the overpayment, the insurer, health care center, third-party administrator or exempt insurer (I) notifies the commissioner of the amount of the overpayment, and (II) provides the commissioner with evidence sufficient to prove the amount of the overpayment.

(B) Not later than ninety days following receipt of notice and supporting evidence under subparagraph (A) of this subdivision, the commissioner shall (i) determine whether the insurer, health care center, third-party administrator or exempt insurer made an overpayment, and (ii) notify the insurer, health care center, third-party administrator or exempt insurer of such determination.

(C) Failure of an insurer, health care center, third-party administrator or exempt insurer to notify the commissioner of the amount of an overpayment within the time prescribed in subparagraph (A) of this subdivision constitutes a waiver of any demand of the insurer, health care center, third-party administrator or exempt insurer against the state on account of such overpayment.

(D) Nothing in this subdivision shall be construed to prohibit or limit the right of an insurer, health care center, third-party administrator or exempt insurer to appeal pursuant to subparagraph (B) of subdivision (5) of this section.

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Technical Amendment to Expedited External Review Timeline
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Consumer Affairs
Drafter	Jennifer Dowty

Overview

Brief Summary of Proposal

Amends the existing Insurance law setting forth the expedited external review timeline by starting the timeline upon an initial determination that the request is complete and eligible for review rather than upon assignment by the Department. Also amends such law to ensure the independent review organization receives notice following a preliminary review of a request by the carrier.

What problem is this proposal looking to solve?

Looking to correct an inconsistency created between the individual timelines afforded to each step and the overall timeline for a response to an expedited external review.

How does the proposal solve the problem?

The proposal will start the timeline once it is determined that the request is complete and eligible for review following a preliminary review by the carrier. This change will resolve the current inconsistencies which are created by starting the timeline at assignment of an independent review organization by the Insurance Department which currently happens at the same time the request is submitted to the carrier for preliminary review.

Section by section summary:

Section #(s)	Section Summary
1	Ensures the independent review organization receives notice following a preliminary review of a request by the carrier.
2	Revises the expedited external review timeline by starting the timeline upon an initial determination that the request is complete and eligible for review rather than upon assignment by the Department.

Statutory Reference: 38a-591g(i)

Background

☒ New Proposal ☐ Resubmission

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	N/A
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Section 1. Subsection (e) of section 38a-591g of the general statutes is repealed and substituted in lieu thereof (Effective July 1, 2026):

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

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

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

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

(3) Not later than five business days after the health carrier receives the copy of an external review request or one calendar day after the health carrier receives the copy of an expedited external review request, from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

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

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

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

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

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

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

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

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

(III) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment; and

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

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

(II) Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or the final adverse determination is likely

to be more beneficial to the covered person than any available standard health care services or treatments;

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

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

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

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

(C) If the request:

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

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

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

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

Sec. 2. Subsection (i) of section 38a-591g of the general statutes is repealed and substituted in lieu thereof (Effective July 1, 2026):

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

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

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

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

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

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

(2) Such notice shall include:

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

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

(C) The date the review was conducted;

(D) The date the organization made its decision;

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

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

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

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

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

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

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

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

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

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

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Amendment to Insurance Statute Referencing NADA Used Car Guide
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Consumer Affairs
Drafter	Theresa Caldarone

Overview

Brief Summary of Proposal

The Proposal makes a technical correction to C.G.S. §38a-353(a) to add language "or its successors" after "National Automobile Dealers Association", which sold its vehicle valuation service to J.D. Power.

What problem is this proposal looking to solve?

J.D. Power acquired the National Automobile Dealers Association ("NADA") vehicle valuation service, so the reference in C.G.S. §38a-353(a) to NADA is no longer correct.

How does the proposal solve the problem?

Adding "or its successors" after "National Automobile Dealers Association" would accurately reflect that NADA's used car guide service is now owned by a successor.

Section by section summary:

Section #(s)	Section Summary
Section 1	Section 1 repeals C.G.S.§38a-353(a) and replaces it with substitute language for the purpose of adding "or its successors" after "National Automobile Dealers Association".

Statutory Reference: C.G.S. §38a-353(a)

Background

☒ New Proposal ☐ Resubmission

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	N/A
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Sec. 1 Sec. 38a-353(a) of the general statutes is repealed and the following substituted in lieu thereof. (*Effective Upon Passage)*

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

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Assumption Reinsurance
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Financial Regulation
Drafter	Anthony Francini

Overview

Brief Summary of Proposal

This proposal seeks to implement the NAIC Model Law regarding assumption reinsurance.

What problem is this proposal looking to solve?

Connecticut insurance law currently has a "bulk reinsurance" statute, which governs assumption reinsurance agreements (i.e., novation of in force insurance policies resulting in the transfer of the policies from one insurance company to another insurance company). However, the current bulk reinsurance statute does not specify the process for providing notice of the assumption transaction to and obtaining consent from affected policyholders.

How does the proposal solve the problem?

By implementing the NAIC Model Law on assumption reinsurance, the Connecticut Insurance Law will specify a process for providing required notice to policyholders regarding their rights related to the assumption of their insurance policy by a substitute insurance company and obtaining consent of such policyholders for such transaction.

Section by section summary:

Section #(s)	Section Summary
1	Repeals C.G.S. § 38a-66
2	Replaces C.G.S. § 38a-66 with the NAIC Model Law on Assumption Reinsurance. This section sets forth definitions applicable to this section, notice requirements for assumption reinsurance transactions, policyholder rights under assumption reinsurance agreements, the effect of policyholder consent and the Insurance Commissioner's discretion in situations where an insurer is in a hazardous financial condition.
3	Amends the property and casualty guaranty association coverage to apply to assumption of obligations resulting from an assumption reinsurance agreement effected through Section 2(g) of this Act.
4	Amends the life and health guaranty association coverage to apply to assumption of obligations resulting from an assumption reinsurance agreement effected through Section 2(g) of this Act.

Statutory Reference:	Repeals § 38a-66 and replaces with the NAIC Model Law on Assumption Reinsurance. Amends § 38a-838 to provide property and casualty guaranty association coverage for unlicensed insurers who assume liabilities pursuant to the Insurance Commissioner's discretion under Section 2(g) of this Act. Amends § 38a-860 to provide life and health guaranty association coverage for unlicensed insurers who assume liabilities pursuant to the Insurance Commissioner's discretion under Section 2(g) of this Act.

Background

☒ New Proposal ☐ Resubmission

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

Yes — Colorado, Georgia, Kansas, Maine, Missouri, Nebraska, North Carolina, Oregon, Rhode Island and Vermont have adopted the NAIC Model Law on Assumption Reinsurance. We are not aware of any issues or concerns regarding these states implementation of the NAIC Model Law.

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	☐ Approved ☐ Unresolved
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Section 1. Section 38a-66 of the general statutes is repealed (Effective October 1, 2026).

Section 2. (New) (Effective October 1, 2026):

(a) Definitions.

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

(2) "Assumption reinsurance agreement" means any contract that both (A) Transfers insurance obligations or risks, or both, of existing or in-force contracts of insurance from a transferring insurer to an assuming insurer; and (B) Is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks, or both, under the contracts are extinguished.

(3) "Contract of insurance" means any written agreement between an insurer and policyholder pursuant to which the insurer, in exchange for premium or other consideration, agrees to assume an obligation or risk, or both, of the policyholder or to make payments on behalf of, or to, the policyholder or its beneficiaries; it shall include all property, casualty, life, health, accident, surety, title and annuity business authorized to be written pursuant to the insurance laws of this state.

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

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

(6) "Policyholder" means any individual or entity which has the right to terminate or otherwise alter the terms of a contract of insurance. It includes any certificateholder whose

certificate is in force on the proposed effective date of the assumption, if the certificateholder has the right to keep the certificate in force without change in benefit following termination of the group policy. The right to keep the certificate in force referred to in this section shall not include the right to elect individual coverage under the Consolidated Omnibus Budget Reconciliation Act, ("COBRA") Section 601, et seq., of the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1161 et seq.).

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

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

(2) This section does not apply to:

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

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

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

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

(E) Any reinsurance agreement or transaction to which a state insurance guaranty association is a party, provided that policyholders do not lose any rights or claims afforded under their original policies pursuant to Chapter 704A; or

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

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

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

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

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

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

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

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

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

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

(H) The address and phone number of the insurance department where the policyholder resides so that the policyholder may write or call the insurance department for further information regarding the financial condition of the assuming insurer.

(l) The following financial data for both companies:

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

(ii) A balance sheet as of December 31 for the previous three (3) years if available or for such lesser period as is available and as of the date of the most recent quarterly statement;

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

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

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

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

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

(d)(1) Prior approval by the commissioner is required for any transaction where an insurer domiciled in this state assumes or transfers obligations or risks, or both, on contracts of insurance under an assumption reinsurance agreement. No insurer licensed in this state shall transfer obligations or risks, or both, on contracts of insurance issued to or owned by residents of this state to any insurer that is not licensed in this state. An insurer domiciled in this state shall not assume obligations or risks, or both, on contracts of insurance issued to or owned by policyholders residing in any other state unless it is licensed in the other state,

or the insurance regulatory official of that state has approved the assumption.

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

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

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

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

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

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

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

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

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

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

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

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

(f) If a policyholder consents to the transfer pursuant to subsection (e) of this section or if the transfer is effected under subsection (g) of this section, there shall be a novation of the contract of insurance subject to the assumption reinsurance agreement with the result that the transferring insurer shall thereby be relieved of all insurance obligations or risks, or both, transferred under the assumption reinsurance agreement and the assuming insurer shall become directly and solely liable to the policyholder for those insurance obligations or risks, or both.

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

(h) The commissioner may adopt regulations, in accordance with chapter 54, to establish the form of Notice of transfer required in this section.

Section 3. Subsection (5)(B) of 38a-838 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2026):

(B) "Covered claim" does not include (i) any claim by or for the benefit of any reinsurer, insurer, insurance pool or underwriting association, as subrogation recoveries or otherwise, provided a claim for any such amount, asserted against a person insured under a policy issued by an insurer that has become an insolvent insurer, that, if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association, would be

a “covered claim”, may be filed directly with the receiver of the insolvent insurer but in no event shall any such claim be asserted against the insured of such insolvent insurer, (ii) any claim by or on behalf of an individual who is neither a citizen of the United States nor an alien legally resident in the United States at the time of the insured event, or an entity other than an individual whose principal place of business is not in the United States at the time of the insured event, and it arises out of an accident, occurrence, offense, act, error or omission that takes place outside of the United States, or a loss to property normally located outside of the United States or, if a workers' compensation claim, it arises out of employment outside of the United States, (iii) any claim by or on behalf of a person who is not a resident of this state, other than a claim for compensation or any other benefit that arises out of and is within the coverage of a workers' compensation policy, against an insured whose net worth at the time the policy was issued or at any time thereafter exceeded twenty-five million dollars, provided an insured's net worth for purposes of this section and section 38a-844 shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis, (iv) any claim by or on behalf of an affiliate of the insolvent insurer at the time the policy was issued or at the time of the insured event, (v) any claim arising out of a policy issued by an insurer that was not licensed to transact insurance in this state at the time the policy was issued, when it assumed the obligation for the covered claim or when the insured event occurred, unless the assumption of the obligation was effected pursuant to section 2(g) of this Act, (vi) any amount due under any policy originally issued by a surplus lines carrier, risk retention group, self-insurer or group self-insurer, (vii) any obligation assumed by an insolvent insurer after the commencement of any delinquency proceeding, as defined in section 38a-905, involving the insolvent insurer or the original insurer, unless it would have been a covered claim absent such assumption, or (viii) any obligation assumed by an insolvent insurer in a transaction in which the original insurer remains separately liable;

Section 4. Subsection (a) of 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2026):

(a) Sections 38a-858 to 38a-875, inclusive, shall provide coverage for the policies and contracts specified in subsection (f) of this section: (1) To any person, except for a nonresident certificate holder under a group policy or contract, who is the beneficiary,

assignee or payee, including a health care provider rendering services covered under a health insurance policy or certificate, of the person covered under subdivision (2) of this subsection, regardless of where the person resides, and (2) any person who is the owner of, or certificate holder or enrollee under, such policy or contract, other than an unallocated annuity contract or a structured settlement annuity, and in each case who (A) is a resident, or (B) is not a resident, provided (i) the member insurer that issued such policy or contract is domiciled in this state, (ii) the state in which the person resides has an association similar to the association created by this section and sections 38a-837, 38a-838, 38a-845, 38a-853, 38a-859, 38a-862, 38a-863, 38a-865, and 38a-866, and (iii) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the state in which the person resides at the time specified in the state's guaranty association law, unless the assumption of the obligation was effected pursuant to section 2(g) of this Act.

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Clarification of Prescription Drug Formulary Change Notice Requirements
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Life & Health
Drafter	Jennifer Dowty

Overview

Brief Summary of Proposal

Provides clarification to the scope of the existing notifications required for changes to prescription drug formularies.

What problem is this proposal looking to solve?

Requires that covered individuals and the covered individuals' treating physicians receive adequate notice of the removal of a prescription drug from a formulary for changes that will occur at renewal.

How does the proposal solve the problem?

Adds clarifying language to the existing statute

Section by section summary:

Section #(s)	Section Summary
1	Requires advance notice to covered individuals and their physicians regarding changes to drug formularies upon renewal of a health benefit plan.

Statutory Reference:	38a-477jj

Background

☒ New Proposal ☐ Resubmission

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State

No

Municipal

No

Federal

No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Section 1. Subdivisions (c) through (e) of section 38a-477jj of the general statutes are repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

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

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

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

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

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

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

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

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

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

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

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

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	An Act Concerning Insurance Department Efficiency Improvements
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Licensing and Market Conduct
Drafter	Antonio Caporale

Overview

Brief Summary of Proposal

This proposal introduces Insurance Department efficiency improvement including electronic delivery of (1) process documents received by the Department; (2) notices to licensees and companies; and (3) communications relating to administrative actions.

What problem is this proposal looking to solve?

The proposal seeks to achieve cost savings by improving, making it more efficient and streamlining Department processes.

How does the proposal solve the problem?

Allows for the use of electronic means of communication in lieu of using the U.S. Postal Service.

Section by section summary:

Section #(s)	Section Summary
1, 2 and 3	These sections amend insurance statutes to allow for documents relating to service of process, notices to licensees and insurers and communication relating to administrative actions to be provided by the Department by electronic means.

Statutory Reference:	C.G.S. Sections 38a-26, 38a-774, 4-182, 51-344b

Background

☐ New Proposal ☒ Resubmission

If resubmission, please provide details below. Please also note any changes made since the last submission:

Bill #(s)	Reason bill(s) did not move forward
HB 6437	Apparent misunderstanding by legislators about the effects of the proposals

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	☐ Approved ☐ Unresolved
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State Yes	The Department's ability to provide notices by electronic means will result in undetermined savings in mailing and personnel costs due to more efficient processes.
Municipal No	
Federal No	

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

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

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

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

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

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

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

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

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

(b) Notwithstanding the provisions of subsection (c) of section 4-182, the commissioner may provide notice of suspension or revocation of a license pursuant to this section or section 4-182 to any person licensed by or registered with the commissioner by personal delivery, as defined in section 4-166. For any firm, association or corporation licensed by or registered with the commissioner, the electronic mail address of any natural persons designated as a primary contact by such firm, association or corporation shall constitute an acceptable means of communication for personal delivery, and a notice sent by electronic mail to such primary contact at such electronic mail address shall constitute notice of suspension or revocation of such license. For any natural person licensed by or registered with the commissioner, the electronic mail address for such licensed or registered person shall constitute an acceptable means of communication for personal delivery, and a notice sent by electronic mail to such natural person's electronic mail address shall constitute notice of suspension or revocation of such license. Any notice provided in accordance with the provisions of this section shall be deemed received by such primary contact or natural person on the earlier of the date of actual receipt by such primary contact or natural person to whom such notice was sent or seven days after the date such notice is postmarked or sent by electronic mail.

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

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

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

Whenever the term "judicial district of Hartford" is used or referred to in the following sections of the general statutes, the term "judicial district of New Britain" shall be substituted in lieu thereof: Subsection (b) of section 3-70a, sections 3-71a and 4-164, subsection (c) of section 4-183, subdivision (4) of subsection (g) of section 10-153e, subparagraph (C) of subdivision (4) of subsection (e) of section 10a-109n, sections 12-3a, 12-89, 12-103, 12-208, 12-237, 12-242hh, 12-242ii, 12-242kk, 12-268*l*, 12-307, 12-312, 12-330m, 12-405k, 12-422, 12-448, 12-454, 12-463, 12-489, 12-522, 12-554, 12-586g and 12-597, subsection (b) of section 12-638i, sections 12-730, 14-57, 14-66, 14-195, 14-324, 14-331 and 19a-85, subsection (f) of section 19a-332e, sections 20-156, 20-247, 20-307, 20-373, 20-583 and 21a-55, subsection (e) of section 22-7, sections 22-320d and 22-386, subsection (e) of section 22a-6b, section 22a-30, subsection (a) of section 22a-34, subsection (b) of section 22a-34, section 22a-182a, subsection (f) of section 22a-225, sections 22a-227, 22a-344, 22a-374, 22a-408 and 22a-449g, subsection (f) of section 25-32e, section 29-158, subsection (f) of section 29-161z, sections 36b-30 and 36b-76, subsection (f) of section 38a-41, section 38a-52, subsection (c) of section 38a-150, sections 38a-185, 38a-209 and 38a-225, subdivision (3) of section 38a-226b, sections 38a-241, 38a-337 and 38a-657, subsection [(c)] (d) of section 38a-774, as amended by this act, section 38a-776, subsection (c) of section 38a-817 and section 38a-994.

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	An Act Concerning Licensing and Market Conduct
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Licensing and Market Conduct
Drafter	Tony Caporale

Overview

Brief Summary of Proposal

Section 1 amends statutory provisions relating to third-party administrators to (a) require that they continue to provide services to insurers in the event of insolvency or receivership; and (b) condition the license renewal of third-party administrators to their compliance with the statutory health and welfare fee assessment. Section 2 eliminates the requirement that at least on audit of third-party administrators by insurers be performed on-site. Section 3 mandates that insurance companies report for cause terminations of any of their agents to the Commissioner within 30 days. Section 4 eliminates the requirement that insurance companies file annual reports concerning claim fraud under automobile insurance policies. Section 5 eliminates the requirements that viatical settlement providers file a report about settled insurance policies with the Commissioner. Section 6 introduces continuing education requirements for casualty claims adjusters.

What problem is this proposal looking to solve?

The proposal - in addition to eliminating issues relating to TPAs failure to report business and/or pay required assessments, and failure to continue services during insurer insolvencies – seek to (a) improve, make more efficient and streamline the Department's processes and to eliminate outdated requirements; and (b) increase consumer protections during the claim adjusting process .

How does the proposal solve the problem?

The proposal seeks to address the issue presented by: (a) requiring TPAs to continue to provide services to insurers in the event of insolvency or receivership; (b) conditioning TPAs license renewal to their compliance with the statutory health and welfare fee reporting and assessment requirements; (c) eliminating the requirements that (i) insurance companies file annual reports concerning claim fraud under automobile insurance policies, which information is available from other sources; (ii) at least on audit of third-party administrators by insurers be performed on-site; and (iii) viatical settlement providers file a report about settled insurance policies with the Commissioner; (d) mandating that insurance companies report for cause terminations of any of their agents to the Commissioner within 30 days; and (e) introducing continuing education requirements for casualty claims adjusters to promote a more knowledgeable and professional work force.

Section by section summary:

Section #(s)	Section Summary
1	Section 1 amends statutory provisions relating to third-party administrators to (a) require that they continue to provide services to insurers in the event of insolvency or receivership; and (b) condition the license renewal of third-party administrators to their compliance with the statutory health and welfare fee reporting and assessment requirements.
2	Section 2 eliminates the requirement that at least on audit of third-party administrators by insurers be performed on-site
3	Section 3 mandates that insurance companies report for cause terminations of any of their agents to the Commissioner within 30 days
4	Section 4 eliminates the requirement that insurance companies file annual reports concerning claim fraud under automobile insurance policies.
5	Section 5 eliminates the requirements that viatical settlement providers file a report about settled insurance policies with the Commissioner.
6	Section 6 introduces continuing education requirements for casualty claims adjusters.

Statutory Reference:	C.G.S. sec. 38a-720; 38a-720e; 38a-708; 38a-356; 38a-465d; 38a-792

Background

☐ New Proposal ☒ Resubmission

If resubmission, please provide details below. Please also note any changes made since the last submission:

Bill #(s)	Reason bill(s) did not move forward
HB 6437	HB 6437 included the proposals set forth below together with proposals related to electronic notices. There was an apparent misunderstanding by legislators about the effects of the proposals pertaining to electronic notices resulting in HB 6437 not moving forward. The electronic notice proposals are not included in this proposal.

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No

Have certain constituencies called for this proposal?

No

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	☐ Approved ☐ Unresolved
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below:

As it concerns section 1, The reason for the requirement that TPA agreements include an insolvency clause is that we have seen instances in other states where TPAs were not willing to continue to provide services following the commencement of a receivership proceeding. This has not been an issue in Connecticut to date, but it is critical that TPAs continue to perform in the event of a receivership. We note that this type of provision is

consistent with what we require for affiliate administrative services agreements and reinsurance agreements.

As it concerns section 1(b), currently our oversight of TPAs is limited. This change will allow us to confirm that TPAs are appropriately reporting all business as part of the health and welfare fee assessment process – and, as a result paying, an appropriate share of the assessment. As of 12/31/2024, for the assessment billed in January 2025 (2024 enrolled lives), we had 107 TPA's report assessment business. As of this month we have received several corrections/edits to this assessment resulting in 108 reporting TPA's reporting. The number of TPAs licensed in Connecticut as of 12/31/24 was 364. We also note that historically, TPAs have not reported accurate information and seek adjustments months after the reporting objection period has passed. We expect that the tie between the required reporting and the TPA licensing requirement will encourage accurate and timely reporting, and reduce the work required to respond to untimely supplemental reporting.

As it concerns section 5, the report currently required is unnecessary because the data concerning insurance policies is maintained by the viatical settlement providers, who are legally required to promptly provide any information, including specific information about policies placed in the settlement market, to the Commissioner upon request. In addition, other than for statistical purposes, such data is of limited usefulness to the Commissioner, as of to date we have never used for any purpose the information captured in the reports received in the past.

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

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

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

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

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

(c) No third-party administrator shall act as such without a written agreement between such third-party administrator and an insurer or other person utilizing the services of the third-party administrator, which shall be retained as part of the official records of both the third-party administrator and such insurer or other person for the duration of such agreement and for five years thereafter. The agreement shall contain all provisions

required by this section, except insofar as those provisions that do not apply to the activities performed by the third-party administrator.

(d) The written agreement set forth in subsection (c) of this section shall include, but not be limited to:(1) A statement of activities that the third-party administrator shall undertake on behalf of the insurer or other person utilizing the services of the third-party administrator, and the lines, classes or types of insurance such third-party administrator is authorized to administer; (2) A statement of the activities and responsibilities of the third-party administrator regarding the administration of or any standards pertaining to business underwritten by the insurer, benefits, premium rates, underwriting criteria or claims payment; (3) A provision requiring the third-party administrator to render an accounting, on such frequency as the parties agree, that details all transactions performed by the third-party administrator pertaining to the business underwritten by the insurer or the business of the person utilizing the services of the third-party administrator; (4) The procedures for any withdrawals to be made by the third-party administrator from the fiduciary account established under section 38a-720f. Such procedures shall address, but not be limited to: (A) Remittance to an insurer or other person utilizing the services of the third-party administrator who is entitled to remittance, (B) deposit in an account maintained in the name of the insurer or other person utilizing the services of the third-party administrator, (C) transfer to and deposit in a claims-paying account, with claims to be paid as provided for in subsection (d) of section 38a-720f, (D) payment to a group policyholder for remittance to the insurer or other person utilizing the services of the third-party administrator entitled to such remittance, (E) payment to the third-party administrator for its commissions, fees or charges, and (F) remittance of return premiums to the person or persons entitled to such return premiums; (5) Procedures and requirements for the disclosures required to be made by the third-party administrator under section 38a-720h; [and] (6) A termination provision, by which either party to the written agreement may terminate such agreement for cause, that includes a procedure to resolve any disputes regarding the cause for termination of such agreement; <u>and (7) A provision requiring the third-party administrator to continue to provide the services contemplated under the agreement in the event of the insolvency or receivership of the insurer</u>.

(e) A third-party administrator or insurer or other person utilizing the services of the third-party administrator may, with written notice, terminate the written agreement for cause as provided in such written agreement. The insurer may suspend the underwriting authority of the third-party administrator during the pendency of any dispute regarding the cause for termination of the written agreement. The insurer or other person utilizing

the services of the third-party administrator shall fulfill any legal obligations with respect to policies or plans affected by the written agreement, regardless of any dispute between the third-party administrator and the insurer or other person utilizing the services of the third-party administrator.

(f) No license issued to a third-party administrator shall be renewed unless the third-party administrator has complied with the requirements of section 19a-7j of the Connecticut General Statutes.

SECTION 2. Section 38a-720e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

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

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

SECTION 3. Section 38a-708 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

Upon the request of the Insurance Commissioner, any insurance company shall furnish to the Insurance Department the facts relative to the termination of an agent's appointment and the causes thereof. If a company terminates an agent's appointment for cause, such termination shall be reported to commissioner not later than 30 calendar days after such

termination. No agent shall have a cause of action against any insurance company as a result of such company's having furnished to said department pursuant to this section any statement, oral or written, unless such statement is false and was known by such company to be false when made.

SECTION 4. Section 38a-356 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

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

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

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

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

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

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

SECTION 5. Section 38a-465d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

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

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

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

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

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

SECTION 6. Section 38a-792 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

(a)(1) No person may act as an adjuster of casualty claims for any insurance company or firm or corporation engaged in the adjustment of casualty claims unless such person has first secured a license from the commissioner, and has paid the license fee specified in section 38a-11, for each two-year period or fraction thereof. Application for such license shall be made as provided in section 38a-769. Any initial license issued to an adjuster of casualty claims shall expire two years after the date of the licensee's birthday that preceded the date the license was issued unless sooner revoked or suspended. The licensee may, at the discretion of the commissioner, renew the license biennially thereafter upon payment of the fee specified in section 38a-11.

(2) The commissioner may waive the examination required under section 38a-769, in the case of any applicant for a casualty claims adjuster's license that (A) is a nonresident

of this state or has its principal place of business in another state, and holds an equivalent license from any other state, or (B) at any time within two years next preceding the date of application has been licensed in this state under a license of the same type as the license applied for.

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

(c) Any person who violates any provision of this section shall be fined not more than two thousand dollars or imprisoned not more than one year or both.

(d) The provisions of this section shall not apply to any:

(1) (A) Individual who, for purposes of claims for portable electronics insurance, as defined in section 38a-397, only (i) collects claim information from or furnishes claim information to insureds or claimants, and (ii) conducts data entry, including data entry into an automated claims adjudication system, provided (I) such individual is an employee of a casualty insurance company licensed in this state, an employee of a casualty claims adjuster licensed in this state or an employee of an affiliate of such insurance company or adjuster, and (II) not more than twenty-five such individuals are under the supervision of a casualty claims adjuster licensed in this state or an insurance producer who adjusts portable electronics insurance claims and is licensed in this state. A licensed insurance producer who adjusts portable electronics insurance claims or supervises individuals pursuant to this subparagraph shall not be required to be licensed as a casualty claims adjuster.

(B) For purposes of this subdivision, "automated claims adjudication system" means a preprogrammed computer system, designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims, that (i) is used only by a supervised individual, a casualty claims adjuster licensed in this state or an insurance producer licensed in this state, in accordance with subparagraph (A) of this subdivision, and (ii) complies with all applicable claims payment requirements under this title; or (2) Member of the bar of this state in good standing who is engaged in the general practice of the law.

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Amendment to terrorism insurance statute
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Property & Casualty and Consumer Affairs
Drafter	Theresa Caldarone & Michael Malesta

Overview

Brief Summary of Proposal

The proposal repeals C.G.S. §38a-307a and replaces it with substitute language that strikes the clause mandating that for any master policy that a condominium association or a unit owners' association is required to purchase, the standard form of fire insurance policy in section 38a-307 shall not exclude coverage for loss by fire or other perils caused by terrorism.

What problem is this proposal looking to solve?

The CID historically has interpreted this provision as requiring condominium associations and unit owners' associations to purchase terrorism coverage if excluded from a master policy. Because the cost of terrorism coverage is significant, condo associations and unit owners' associations want the option to purchase rather than a requirement that coverage be purchased.

How does the proposal solve the problem?

Removing the language at issue would clarify that condominium associations and unit owners' associations are not required to purchase coverage for losses caused by terrorism.

Section by section summary:

Section #(s)	Section Summary
1	This section repeals C.G.S. §38a-307a and replaces it with substitute language that strikes the clause mandating that for any master policy that a condominium association is required to purchase under 47-83 and that a unit owners' association is required to purchase under 47-255, the standard form of fire insurance policy under section 38a-307 shall not exclude coverage for loss by fire or other perils insured against in the policy caused by terrorism.

Statutory Reference:	**C.G.S. §38a-307a**

Background

☒ New Proposal ☐ Resubmission

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

No	Not to our knowledge.

Have certain constituencies called for this proposal?

Yes	Questions have been brought to the CID by board members of condominium associations asking what insurance coverage they must purchase to comply with state law.

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below:

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Sec. 1. Sec. 38a-307a of the general statutes is repealed and the following substituted in lieu thereof (*Effective Upon Passage)*:

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

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Premium Billing Notice Disclosure
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Property & Casualty
Drafter	Michael Malesta & Theresa Caldarone

Overview

Brief Summary of Proposal

The proposal codifies the Premium Increase Transparency Disclosure Notice Guidance for States ("Guidance") adopted on November 12, 2024 by the NAIC's Transparency and Readability of Consumer Information (C) Working Group (that was chaired by the CID's Director of the P & C Division). The NAIC's Property and Casualty Insurance (C) Committee adopted the Guidance on November 19, 2024. The proposal implements the Guidance in two phases. The first phase, which would take effect on July 1, 2026, requires that premium billing notices for a personal risk insurance policy under 38a-663 provide a reasonable explanation for premium increases not later than twenty days after the insured requests, in writing, information about the reasons for the premium increase. (Personal risk insurance under 38a-663 means homeowners, tenants, private passenger non-fleet automobile, mobile manufactured home and other property and casualty insurance for personal, family or household needs except workers' compensation insurance.) The second phase would take effect on January 1, 2029. Under the second phase, with respect to the renewal of any personal risk insurance policy having a premium billing increase of ten percent or more, the premium billing notice shall provide the dollar impact or an estimate of the dollar impact of the increase attributable to each primary factor.

What problem is this proposal looking to solve?

Current law does not require that premium billing notices for a personal risk insurance policy provide an explanation for a premium increase. Requiring insurers to provide an

explanation as to why an insured's premium went up would help the consumer to understand the reason for the increase in premium.

How does the proposal solve the problem?

As the industry is using more data elements to determine a rate, consumers are often unaware of what information is being used. This proposal will now require a company to provide the consumer with specific information as to what data was used causing their rate to increase more than ten percent.

Section by section summary

Section #(s)	Section Summary
1	Section 1, which takes effect July 1, 2026, repeals Subsection (b) of Section 38a-323 and replaces it with substitute language. Section 1 adds language to C.G.S. §38a-323(b)(1) that authorizes insurers to send premium billing notices to insureds by electronic means if the insured agrees. It also adds language stating that premium billing notices for a personal risk insurance policy under section 38a-663 shall provide a reasonable explanation for premium increases not later than twenty days after the named insured requests, in writing, information about the reasons for such premium increase. Section 1 defines "reasonable explanation" as "sufficient information, in terms that are understandable to an average policyholder, which enables the policyholder to determine the basic nature of any premium increase." Section 1 also adds a new subsection (3) to C.G.S. §38a-323(b). The new subsection (3) states that insurers shall include a prominent statement at the beginning of the first page of the premium billing notice that includes contact information of the insurer so that the insured may request additional information concerning the premium increase.
2	Section 2 amends subsection (b) of C.G.S. §38a-323 by adding subdivision 4, which would become effective January 1, 2029. Section 2 states that with respect to the renewal of any personal risk insurance policy under C.G.S. §38a-663 having a premium billing

	increase of ten percent or more, the premium billing notice shall provide the dollar impact or an estimate of the dollar impact of the increase attributable to each primary factor. If the premium billing notice uses estimated dollars, the insurer must provide a reasonable explanation of the degree of accuracy achieved by the use of estimated dollars. Section 2 states that it does not apply to premium increases of one hundred dollars or more and mandates that the Commissioner adopt regulations to implement the requirements of this subsection.

Statutory Reference:	C.G.S. §38a-323(a)(1) & (b)

Background

☒ New Proposal ☐ Resubmission

If resubmission, please provide details below. Please also note any changes made since the last submission:

Bill #(s)	**Reason bill(s) did not move forward**

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

Yes	The State of Washington adopted new premium change transparency rules in Chapter 284-30A WAC. The first phase went into effect June 1, 2024.

Have certain constituencies called for this proposal?

Yes	This proposal would assist consumers in understanding why their insurance premiums increased.

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	☐ Approved ☐ Unresolved
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

Sec. 1. Subsection (b) of section 38a-323 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2026):

(1) A premium billing notice for any policy subject to the requirements of sections 38a-663 to 38a-696, inclusive, except a workers' compensation policy, shall be mailed or delivered to the insured by the insurer or its agent or, if agreed between the insurer and the named insured, by electronic means, not less than thirty days in advance of the policy's renewal or anniversary date, except that such notice shall not be required for a commercial risk policy if the premium for the ensuing policy period is to increase less than ten per cent on an annual basis. The premium billing notice for a personal risk insurance policy under section 38a-663 shall (i) provide a reasonable explanation for premium increases not later than twenty days after the named insured requests, in writing, information about the reasons for such premium increase; (ii) be based on the rates and rules applicable to the ensuing policy period; and (iii) [shall] include a notice of transfer when the policy has been transferred from an insurer to an affiliate of such insurer pursuant to the provisions of subparagraph (C) of subdivision (1) of subsection (a) of this section. As used herein, a reasonable explanation means sufficient information, in terms that are understandable to an average policyholder, which enables the policyholder to determine the basic nature of any premium increase. The provisions of this subsection shall apply to any such policy for which the annual premium was less than fifty thousand dollars for the preceding annual policy period.

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

(3) An insurer shall include a prominent statement at the beginning of the first page of the premium billing notice for personal risk insurance policies that includes contact information of the insurer in order that the insured may request additional information concerning the premium increase.

Sec. 2 (NEW) Subsection (b) of section 38a-323 of the general statutes is amended and the following is substituted in lieu thereof (Effective January 1, 2029):

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

Agency Legislative Proposal

2026 Session

General Information

Agency	**Dept. of Insurance**
Proposal Name	Changes to The Connecticut Insurance Guaranty Association Act
Legislative Liaison	Alex Borkowski & Mary Quinn
Division Requesting Proposal	Legal
Drafter	Anthony Francini

Overview

Brief Summary of Proposal

This proposal amends the Connecticut Guaranty Association Act with updates from the NAIC Model Law regarding the property and casualty insurance guaranty association.

What problem is this proposal looking to solve?

This proposal seeks to expand guaranty association coverage to cybersecurity insurance, increase first party real property coverage and unearned premium amounts, reduce administrative burdens and update the statutes based on developments at the NAIC and in the insurance industry.

How does the proposal solve the problem?

This proposal addresses the above referenced problems by (1) providing guaranty association coverage for cybersecurity insurance policies and capping claims at $500,000 per single insured event, (2) providing guaranty association coverage for insurance policies subject to a corporate division and insurance business transfer transactions, (3) increasing the limit on unearned premium claims, (4) eliminating the $100 deductible on certain claims that create an administrative burden, (5) providing up to $1 million in coverage for first party real property claims, (6) clarifying provisions providing the guaranty association with protections from lawsuits in remote venues, and (7) clarifying the guaranty association's ability to hire outside service providers to assist in covering cybersecurity insurance claims.

Section #(s)	Section Summary
1	Amends the application of the chapter to include cybersecurity insurance policies.
2	Amends definitions to define cybersecurity insurance and provide coverage for insurance policies allocated, transferred, merged into, novated, assumed by, or otherwise made the sole responsibility of another member insurer.
3	Amendments to this section (i) increase guaranty association coverage for homeowners and (ii) add provisions for coverage of cybersecurity insurance policies.

Statutory Reference:	§ 38a-837. Application of chapter. § 38a-838. Definitions § 38a-841. Obligations and rights of association. Limitations. Assessments. Investigations of Claims. Right to intervene in court proceedings. § 38a-836 to 38a-853, inclusive – Connecticut Insurance Guaranty Association Act

Background

☒ New Proposal ☐ Resubmission

Have there been any changes in federal laws or regulations that make this legislation necessary?

No

Have there been any changes in state laws or regulations that make this legislation necessary?

No

Has this proposal or a similar proposal been implemented in other states?

Yes	Kansas, Kentucky, Maine, Massachusetts, Nebraska, Oklahoma, Oregon, and Rhode Island legislatures have adopted the most recent version of

	the NAIC Model Law. The Department is not aware of any issues in those states regarding the NAIC Model Law. Massachusetts recently increased first party real property coverage to $1 million due to today's real estate market. We are not aware of any issues with this increase.

Have certain constituencies called for this proposal?	
Yes	The Connecticut Insurance Guaranty Association has requested these amendments.

Interagency Impact

☒ Check here if this proposal does NOT impact other agencies

Agency	N/A
Contact	N/A
Date Contacted	N/A
Status	
Open Issues	N/A

Fiscal Impact

☒ No Fiscal Impact

☐ Budget Option Submitted

Include the section number(s) which have a fiscal impact and the anticipated impact:

State
No
Municipal
No
Federal
No

Other Information

If there is any additional information we should know, please detail below: N/A

Legislative Language

Insert fully drafted bill below. Please use standard legislative drafting considerations, as published by LCO here.

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

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

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

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

(3) Fidelity or surety or any bonding obligations;

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

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

(6) Title insurance;

(7) Ocean marine insurance

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

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

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

Section 2. Section 38a-838 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2026):

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

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

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

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

(4) “Commissioner” means the Insurance Commissioner;

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

made the sole responsibility of another member or non-member insurer if all the following conditions are satisfied: (i) the original member insurer has no remaining obligations on the policy after the transfer; (ii) a final order of liquidation with a finding of insolvency has been entered against the insurer that assumed the member insurer's coverage obligations by a court of competent jurisdiction in the insurer's State of domicile; (iii) the claim would have been a covered claim, as defined in first sentence of this subsection, if the claim had remained the responsibility of the original member insurer and the order of liquidation had been entered against the original member insurer, with the same claim submission date and liquidation date; and (iv) in cases where the member insurer's coverage obligations were assumed by a non-member insurer, the transaction received prior regulatory or judicial approval.

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

or on behalf of an affiliate of the insolvent insurer at the time the policy was issued or at the time of the insured event, (v) any claim arising out of a policy issued by an insurer that was not licensed to transact insurance in this state at the time the policy was issued, when it assumed the obligation for the covered claim or when the insured event occurred, (vi) any amount due under any policy originally issued by a surplus lines carrier, risk retention group, self-insurer or group self-insurer, (vii) any obligation assumed by an insolvent insurer after the commencement of any delinquency proceeding, as defined in subsection 38a-905, involving the insolvent insurer or the original insurer, unless it would have been a covered claim absent such assumption, or (viii) any obligation assumed by an insolvent insurer in a transaction in which the original insurer remains separately liable;

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

[(6)](7) "Insolvent insurer" means an insurer (A) (i) licensed to transact insurance in this state at the time the policy was issued, [when it assumed the obligation for the covered claim] or when the insured event occurred and (ii) against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile; [(B) that is (i) the legal successor of an that was licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred, by reason of a merger, provided such merger is approved by an insurance regulator having jurisdiction over such merger, and (ii) against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile; or (C) that (i) succeeds to the policy obligations of an insurer that was licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred, by reason of a division whereby policies issued by such licensed insurer are allocated to or otherwise become the obligation of a successor insurer, provided such division is approved (I) in a jurisdiction that allows such division, and (II) by an insurance regulator having jurisdiction over such division, and (ii) against which a final order of liquidation with a finding of insolvency has

been entered by a court of competent jurisdiction in the succeeding insurer's state of domicile. "Insolvent insurer" shall not be construed to mean any insurer with respect to which an order, decree, judgment or finding of insolvency, whether permanent or temporary in nature, or order of rehabilitation or conservation has been issued by a court of competent jurisdiction prior to October 1, 1971];

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

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

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

[(10)](11) "Residence" means, when used in reference to a corporation, its principal place

of business;

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

Section 3. Subsection (a) and (b) of section 38a-841 of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2026):

(a) Said association shall: (1) Be obligated to the extent of the covered claims existing prior to the determination of insolvency or the entry of a final order of liquidation with a finding of insolvency, as applicable, and arising within thirty days after the determination of insolvency or the entry of such order, or before the policy expiration date if less than thirty days after the determination or the entry of such order, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty days after such determination or entry of such order, provided such obligation shall be limited as follows: (A) With respect to covered claims for unearned premiums[, to one-half of the unearned premium on any policy,] subject to a maximum of [two]fifty thousand dollars per policy; (B) with respect to covered claims other than for unearned premiums and those otherwise specified below, such obligation shall include only that amount of each such claim that [is in excess of one hundred dollars and] is equal to or less than (i) three hundred thousand dollars for claims arising under policies of insurers determined to be insolvent prior to October 1, 2007, (ii) four hundred thousand dollars for claims arising under policies of insurers determined to be insolvent on or after October 1, 2007, and prior to October 1, 2015, and (iii) five hundred thousand dollars for claims arising under policies of insurers against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile on or after October 1, 2015[.]; (C) with respect to first-party real property claims arising under policies of insurers determined to be insolvent on or after June 1, 2026, an amount not exceeding $1,000,000 for claims arising from a single occurrence under a policy covering commercial or residential property; (D) in no event shall the association be obligated to pay an amount in excess of $500,000 for all first- and third-party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of claimants. Said association shall pay the full amount of any such claim arising out of a

workers' compensation policy, provided in no event shall said association be obligated (I) to any claimant in an amount in excess of the obligation of the insolvent insurer under the policy form or coverage from which the claim arises, or (II) for any claim filed with the association after the expiration of two years from the date of the declaration of insolvency unless such claim arose out of a workers' compensation policy and was timely filed in accordance with section 31-294c; (2) Be deemed the insurer to the extent of its obligations on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association, provided however that the association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction; (3) Allocate claims paid and expenses incurred among the three accounts, created by section 38a-839, as amended by this act, separately, and assess member insurers separately (A) in respect of each such account for such amounts as shall be necessary to pay the obligations of said association under subdivision (1) of this subsection subsequent to an insolvency (B) the expenses of handling covered claims subsequent to an insolvency; (C) the cost of examinations under section 38a-846 and (D) such other expenses as are authorized by sections 38a-836 to 38a-853, inclusive, as amended by this act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of such member insurer for the calendar year preceding the assessment on the kinds of insurance in such account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance in such account. Each member insurer shall be notified of its assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than two per cent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in said account, provided if, at the time an assessment is levied on the "all other insurance" account, as defined in subdivision (3) of section 38a-839, as amended by this act, the board of directors finds that at least fifty per cent of the total net direct written premiums of a member insurer and all its affiliates, for the year on which such assessment is based, were from policies issued or delivered in Connecticut, on risks located in this state, such member insurer shall be assessed only on such member insurer's net direct written premium that is attributable

to the kind of insurance that gives rise to each covered claim. If the maximum assessment, together with the other assets of said association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. Said association may defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance, provided during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below the minimum amounts required for a certificate of authority. Such payments shall be refunded to those insurers receiving greater assessments because of such deferment or, at the election of the insurer, be credited against future assessments. Each member insurer serving as a servicing facility may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by such member insurer if they are chargeable to the account in respect of which the assessment is made; (4) Investigate claims brought against said association and adjust, compromise, settle, and pay covered claims to the extent of said association's obligations, and deny all other claims. The association shall pay claims in any order it deems reasonable including, but not limited to, payment in the order of receipt or by classification. It may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested: (5) Notify such persons as the commissioner may direct under subdivision (1) of subsection (b) of section 38a-843, as amended by this act; (6) Handle claims through its employees or through one or more insurers or other persons designated by said association as servicing facilities, provided such designation of a servicing facility is approved by the commissioner and may be declined by a member insurer; (7) Reimburse each such servicing facility for obligations of said association paid by such facility and for expenses incurred by such facility while handling claims on behalf of said association and shall pay such other expenses of said association as are authorized by sections 38a-836 to 38a-853, inclusive, as amended by this act.

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