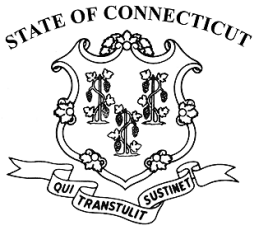

Substitute House Bill No. 5373

Public Act No. 26-69

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

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

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 Section 38a-26 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):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, **[**or**]** post-office address or electronic mail 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 last-known electronic mail address of the person, secretary, designee, resident manager, secretary or officer to be notified, as applicable, 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.

Sec. 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 the primary contact's 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.

Sec. 3. Section 51-344b of the 2026 supplement to 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 and 22a-408, 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.

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 Subdivision (5) of subsection (b) of section 19a-7j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2026*):

(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 commissioner concerning the proposed fee. The commissioner, after making any adjustment that the 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, 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.

Sec. 5. 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 the 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 the 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 the 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 the 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-five**]** 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 the 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. 6. Section 38a-307a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from 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.

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 Subsection (b) of section 38a-323 of the 2026 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2027*):

(b) (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 shall be based on the rates and rules applicable to the ensuing policy period and 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. 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, including by electronic means, shall constitute compliance by such insurer with said subdivision.

(3) For a policy providing personal risk insurance, as defined in section 38a-663, the premium billing notice required pursuant to this subsection shall (A) state that the insurer shall provide a reasonable explanation for premium increases not later than twenty business days after the named insured requests, in writing or by other means of communication, as prescribed by the commissioner, information identifying the reasons for any such premium increase, and (B) include a prominent statement in a location and format prescribed by the commissioner, that includes contact information of such insurer to which such request may be submitted. Any insurer who receives such a request for a reasonable explanation for a premium increase shall provide such reasonable explanation to the insured not later than twenty business days after the date such request is received by such insurer. As used in this subdivision, "reasonable explanation" means sufficient information, in terms that are understandable to an average policyholder that enables the policyholder to determine the basic nature of any premium increase.

Sec. 8. Subsection (a) of section 38a-353 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from 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**]** J.D. Power used car guide or its successor, 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.

Sec. 9. 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.

Sec. 10. 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 wilfully fails to file an annual statement as

required in this section or wilfully 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.

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

(a) For the purposes of this section:

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

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

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

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

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

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

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

(b) Notwithstanding any provision of the general statutes and except as provided in subsection (c) of this section, no 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:

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

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

(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**]** prescribing health care provider, 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**]** prescribing health care provider 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 shall annually, in advance of the applicable open enrollment period for such plan, make available for review by any person, in a readily accessible format, a list of any prescription drugs that are being removed from the formulary and a list of covered drugs effective for the new plan year.

[(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) (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), 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.**]**

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

(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 assigned independent review organization, 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. 13. Subsection (i) of section 38a-591g of the general statutes is

repealed and the following is 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 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.

(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 the 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.

Sec. 14. 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 the commissioner not later than thirty 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.

Sec. 15. 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; 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.

(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, as amended by this act.

Sec. 16. 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.**]**

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

(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.

Sec. 18. 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) **[**Insurance**]** Except for coverages that may be set forth in a

cybersecurity policy, 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.

Sec. 19. 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, as amended by this act, 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 arising from 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 nonmember 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 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

nonmember 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, unless the assumption of the obligation was effected pursuant to subsection (g) of section 23 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;

(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)**]** (B) 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 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 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, as amended by this act, 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; and

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

Sec. 20. 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 claims specified in subparagraph (C) or (D) of this subdivision, such obligation shall include only that amount of each such claim that **[**is in excess of one hundred dollars and**]** is less than or equal to (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 one million dollars for claims arising from a single occurrence under a policy covering commercial or residential property; and (D) in no event shall the association be obligated to pay an amount in excess of five hundred thousand dollars 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)**]** (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)**]** (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 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, 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. 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, 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;

(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.

(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 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, as amended by this act; (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; (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.

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

successive tax years following the year of payment of the assessment, at the rate of twenty per cent per year of the assessment paid to the association. Each insurer to which has been refunded by the association, pursuant to subsection (b) of this section, all or a portion of an assessment previously paid to the association by the insurer shall be required to pay to the Department of Revenue Services an amount equal to the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns, as the case may be, filed by such insurer and that is attributable to such refunded assessment, provided the amount required to be paid to said department shall not exceed the amount of the refunded assessment. If the amount of the refunded assessment exceeds the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such insurer and that is attributable to such refunded assessment, such excess may not be claimed as an offset against the premiums tax liability on a premiums tax return or returns filed by such insurer or, if the offset has been transferred to another person pursuant to subdivision (2) of this subsection, by such other person. For purposes of this subparagraph, if the offset has been transferred to another person pursuant to subdivision (2) of this subsection, the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such insurer includes the total amount that has been claimed as an offset against the premiums tax liability on the premiums tax return or returns filed by such other person. The association shall promptly notify the Commissioner of Revenue Services of the name and address of the insurers to which such refunds have been made, the amount of such refunds and the date on which such refunds were mailed to such insurer. If the amount that an insurer is required to pay to the Department of Revenue Services has not been so paid on or before the forty-fifth day after the date of mailing of such refunds, the insurer shall be liable for interest on such amount at the rate of one per cent per month or fraction thereof from such forty-fifth day to the date

of payment.

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

Sec. 21. Subsection (a) of section 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, as amended by this act, 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 subsection (g) of section 23 of this act.

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

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

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

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

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

(4) "Commissioner" means the Insurance Commissioner.

(5) "Control", "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the person.

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

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

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

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

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

(11) "Insurance" means any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration.

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Assumption reinsurance agreement" means any contract that (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) "Home service business" means any insurance business for which premiums are collected on a weekly or monthly basis by an agent of the insurer.

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

(5) "Policyholder" means any individual or entity that has the right to terminate or otherwise alter the terms of an insurance agreement. "Policyholder" includes any certificate holder whose certificate is in force on the proposed effective date of the assumption, if such certificate holder has the right to keep such certificate in force without a change in benefits following termination of the group policy, except that the right to keep such certificate in force shall not include the right to elect individual coverage under the Consolidated Omnibus Budget Reconciliation Act, Section 601, et seq., of the Employee Retirement Income Security Act of 1974, as amended from time to time.

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

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

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

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

agreement subject to the reinsurance agreement;

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

(C) The transfer of insurance agreements pursuant to mergers or consolidations of two or more insurers to the extent that such mergers or consolidations 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 policyholders do not lose any rights or claims afforded under such policyholders' original policies pursuant to chapter 704a of the general statutes; or

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

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

(2) The notice of transfer shall provide:

(A) The date such transfer and novation of the policyholder's insurance agreement 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 consent to or reject the transfer and novation;

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

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

(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, pursuant to the provisions of this section, to assume such type of business;

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

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

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

(i) Insurance ratings for the last five years, if available, or for such lesser period as is available, from two nationally recognized insurance rating services approved by the commissioner, including each rating service's explanation of the meaning of such ratings. If any such ratings are unavailable for any year of the five-year period, the unavailability of

such ratings shall be disclosed in the notice of transfer;

(ii) A balance sheet as of December thirty-first for the previous three 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 filed as a supplement to the previous year's annual statement; and

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

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

(4) The notice of transfer shall include a preaddressed, postage prepaid response card that each policyholder may return as such policyholder's 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 subdivision (1) of subsection (d) of this section.

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

(2) Any licensed foreign insurer that enters into an assumption reinsurance agreement that transfers the obligations or risks, or both, on insurance agreements issued to or owned by residents of this state shall file or cause to be filed with the commissioner 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 insurers. If no such requirements exist in the domicile of either the transferring or assuming insurers, the requirements of subdivision (3) of this subsection shall apply.

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

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

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

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

(C) The plans or proposals of the assuming insurer applicable to the

administration of the policies subject to the proposed transfer;

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

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

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

(2) Payment of any premium to the assuming insurer 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 the premium notice clearly states that payment of the premium to the assuming insurer shall constitute acceptance of the transfer. 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 shall be set forth in the notice of transfer required pursuant to subsections (c) and (d) of this section and in the assumption certificate.

(3) Not less than twenty-four months after the mailing of the initial notice of transfer required pursuant to subsection (c) of this section, if consent to, or rejection of, the transfer and assumption has not been received or consent has not been deemed to have occurred under

subdivision (2) of this subsection, 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 consent to, 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, such policyholder's consent shall be deemed to have occurred and novation of the insurance agreement will be effected. With respect to any 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 subdivision (1) of subsection (c) of this section.

(4) The transferring insurer shall be deemed to have received the response card on the date it is postmarked, provided if a policyholder provides such policyholder's response card by facsimile or other electronic transmission or by registered mail, express delivery or courier service, such 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 insurance agreement subject to the assumption reinsurance agreement. A novation pursuant to this subsection shall result in (1) the transferring insurer being relieved of all insurance obligations or risks, or both, transferred under the assumption reinsurance agreement, and (2) the assuming insurer being directly and solely liable to such policyholder for such 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, as provided for in section 38a-8-103 of the regulations of Connecticut state agencies, as amended from time

to time, or an administrative proceeding has been instituted against such insurer for the purpose of reorganizing or conserving such insurer, and the transfer of the insurance agreements 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, including, but not limited to, a form of implied consent and adequate notification to such policyholders of the circumstances requiring the transfer as approved by the commissioner.

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

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

(b) (1) **[**When any policy of insurance is procured or renewed under the authority of such license providing a line of insurance or its component that does not, on the effective date of coverage, appear on the current published list, both the licensee and the insured shall first make a diligent effort, as defined by the commissioner, to procure, from any authorized insurer or insurers, the full amount of insurance required to protect the interest of such insured, and further showing (A) that the amount of insurance procured from an unauthorized insurer or insurers is only the excess over the amount so procurable from authorized insurers, (B) the type of policy, and (C) if such policy is for real property, the location of such property. Such licensee shall keep, in a form approved by the commissioner, and make available for examination by the commissioner upon request, all (i) documentation concerning such licensee's and insured's diligent effort to procure, from any authorized insurer or insurers, the full amount of insurance required to protect the interest of such insured, and (ii) information concerning each policy placed in the surplus lines market.**]** <u>The</u>

commissioner may require, annually, that each surplus lines broker, licensed pursuant to section 38a-794, authorized to place surplus lines insurance in this state, submit a report to the commissioner, in a form and manner prescribed by the commissioner, that contains the following information applicable to surplus lines policies issued in this state: (A) The number and types of policies issued; (B) for any policy covering real property, the location of such property, and the total premium paid by insureds for coverage under such policy; and (C) the number of policies renewed in the prior year. The provisions of this subdivision shall not prevent the commissioner from requesting and obtaining any such additional information pursuant to the provisions of this title.

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

Sec. 25. Section 38a-66 of the general statutes is repealed. (*Effective October 1, 2026*)