OLR Bill Analysis

sHB 5373 (as amended by House "A")*

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

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BACKGROUND

SUMMARY

This bill makes several unrelated changes to the insurance statutes, as described in the section-by-section analysis below.

*House Amendment "A" replaces the underlying bill (File 241) and (1) makes minor changes to reasonable explanation requirements for personal risk policy premium billing notices, (2) removes the requirement that certain premium billing notices include the dollar amount of the increase attributable to each primary factor for personal risk policies with a premium increase of at least 10%, (3) makes a technical change to the provision on settlement amounts for totaled vehicles, (4) requires health carriers to provide a formulary drug list prior to a policy's open enrollment period, (5) makes technical changes to provisions on the Connecticut Insurance Guaranty Association (CIGA), (6) makes minor and technical changes to provisions on the National Association of Insurance Commissioners' (NAIC's) assumption reinsurance model law, and (7) adds provisions on surplus lines brokers.

EFFECTIVE DATE: October 1, 2026, except as specified below.

§ 1 — SERVICE OF PROCESS NOTICES

Allows the insurance commissioner to serve notice of process electronically, instead of only by registered or certified mail as under current law

By law, the insurance commissioner acts as agent for service of legal process on specified insurance companies and related entities. The bill allows the commissioner, upon receipt, to send a copy of the legal process to the person to be served electronically, instead of only by registered or certified mail as under current law.

Under existing law and the bill, the commissioner must send a copy of the legal notice to the following individuals: (1) the person to be served at his or her last known business or personal address; (2) for foreign insurance companies, the secretary or designee; (3) for alien insurance companies, the U.S. resident manager (if any); and (4) for fraternal benefit societies, the secretary or corresponding officer.

The bill requires the commissioner, when sending these copies electronically, to send them to the last known email address on file for the individuals listed above.

§§ 2 & 3 — LICENSE SUSPENSION AND REVOCATION NOTICES

Allows the insurance commissioner to deliver license suspension and revocation notices electronically

By law, the insurance commissioner, after notice and a hearing, may suspend or revoke a licensee's license for cause. The bill allows the commissioner, regardless of the Uniform Administrative Procedure Act (UAPA), to send suspension or revocation notices by personal delivery.

By law, "personal delivery" is direct delivery to the intended recipient (or the recipient's designated representative), including electronic delivery to an email address the recipient identified as an acceptable means of communication. Current law requires notice by mail.

The bill specifies that electronic suspension or revocation notices are deemed an acceptable means of communication when sent to a licensee or registrant as follows:

1. to an entity's (firm, association, or corporation) designated primary contact person's email address and

2. to an individual licensee's or registrant's email address.

Under the bill, a notice sent this way is deemed received by the primary contact person or individual on the actual date it was received, or seven days after the date the notice is postmarked or emailed, whichever is earlier.

As under existing law, anyone aggrieved by the commissioner's decision to suspend or revoke a license or registration may appeal to the New Britain Superior Court under the UAPA.

§ 4 — OBJECTION PROCESS FOR HEALTH AND WELFARE FEE

Establishes an objection process for the health and welfare fee that the insurance commissioner assesses against certain insurers, HMOs, and TPAs

By law, the insurance department assesses a health and welfare fee against (1) domestic insurers and HMOs doing business in the state and (2) licensed third-party administrators (TPAs) and domestic insurers not subject to TPA licensure servicing self-insured health benefit plans.

The fee is used to pay the expenses of the Department of Public Health's (DPH) Connecticut Vaccine Program (for example, purchasing and distributing childhood vaccines and administering the immunization information system).

The bill establishes an objection process for the health and welfare fee that is similar to existing law's process for the public health fee (a separate assessment that pays for certain other DPH programs, such as children's health initiatives, AIDS services, and tuberculosis care). More specifically, it allows domestic insurers, HMOs, TPAs, and exempt insurers to submit to the insurance commissioner objections to the proposed fee annually, by December 20. The commissioner must then submit to the objector a final statement, by January 1, that includes any adjustments to the fee he deems necessary.

Under existing law, unchanged by the bill, insurers must pay the health and welfare fee by February 1.

§ 5 — INSURANCE FUND

Adds the Office of the Behavioral Health Advocate to the offices covered by the Insurance Fund general assessment; changes several reporting dates in the general assessment process; changes the installment payment amounts as a percentage of the total assessment

Office of the Behavioral Health Advocate

By law, domestic insurers and HMOs pay an annual general assessment to the Insurance Fund to cover the expenses of the Connecticut Insurance Department (CID), Office of the Healthcare Advocate (OHA), and Office of Health Strategy (OHS), among other things. The bill adds the Office of the Behavioral Health Advocate (OBHA) to the list of entities the assessment covers.

Correspondingly, it adds OBHA to (1) statements the insurance commissioner gives to insurers and HMOs showing appropriations for offices covered by the general assessment, (2) calculations that set the assessment, and (3) calculations to determine the upper limit for insurers' and HMOs' required payments as a percentage of office expenditures.

Reporting Dates

The bill changes, from June 30 to August 31, the date by which the Department of Revenue Services must report to the insurance commissioner the taxes (before allowable credits) paid by domestic insurers and HMOs during the calendar year before the previous calendar year (for example, information given in 2026 would cover 2024).

Under current law, by July 31 annually, CID gives insurers and HMOs that will be assessed a statement showing, among other things, how much was appropriated to the offices covered by the assessment (including CID, OHA, and OHS) from the Insurance Fund for that fiscal year. Under the bill, CID must instead give them the statement by September 15.

Assessment and Payment Installments

Under current law, the commissioner must assess insurers and HMOs, providing for any objections and adjustments, for the fiscal year by September 1 annually. The bill changes this assessment date to October 1.

By law, insurers and HMOs pay the assessment in four installments, each as a certain percentage of the total amount due. Under the bill, the first payment amount (due June 30) increases from 25% to 35%, and the final payment amount (due in equal parts on December 31 and March 31) decreases from 50% to 40%. Additionally, the bill delays the second payment's due date from September 30 to October 31, but the amount remains unchanged (25%).

§ 6 — TERRORISM INSURANCE REQUIREMENT

Eliminates a requirement that condominium and unit owners' associations purchase terrorism insurance

The bill eliminates current law's requirement that a condominium or unit owners' association's master policy include coverage for terrorism if the condominium is subject to the Common Interest Ownership Act or the Condominium Act.

In doing so, the bill allows these master policies to exclude coverage

for losses caused, directly or indirectly, by terrorism (1) if the premiums charged for the policy reflect projected savings from the exclusion and (2) until the Terrorism Risk Insurance Program established under federal law expires.

Background — Federal Terrorism Risk Insurance Act

The 2002 federal Terrorism Risk Insurance Act (P.L. 107-297) created a temporary program under which the federal government shares the risk of loss from foreign terrorist attacks with the insurance industry. The 2019 Terrorism Risk Insurance Program Reauthorization Act revised several provisions of the initial act and extended the program until December 31, 2027.

EFFECTIVE DATE: Upon passage

§ 7 — PREMIUM BILLING NOTICES

Allows certain premium billing notices to be delivered electronically; requires insurers to give a reasonable explanation for premium increases for personal risk policies upon request

Under the bill, an insurer (or its agent) may send premium billing notices for personal or commercial risk insurance electronically if agreed to between the insurer and insured. Under current law, personal and commercial risk insurers must mail or deliver to the named insured a premium billing notice at least 30 days before the policy's renewal or anniversary date. The notice tells the insured the premium amount, length of coverage, and due date. This requirement applies to personal and commercial insurance policies that cost less than $50,000 for the preceding annual policy period. It does not apply to workers' compensation insurance risks or to commercial risks subject to a premium increase of less than 10% for the upcoming policy period. Personal risk insurance includes policies covering homeowners, tenants, private passenger non-fleet automobiles, and mobile manufactured homes, among other things.

Additionally, for personal risk policies, the bill requires the premium billing notice to state that the insurer will give a reasonable explanation for a premium increase within 20 days after an insured asks for one in writing or another way the insurance commissioner sets. Under the bill,

a "reasonable explanation" is sufficient information to allow the policyholder to determine what caused the increase in terms that are understandable to an average policyholder.

The bill also requires insurers to include a prominent statement in a location and format the commissioner sets that includes contact information for the insured to submit the request.

Lastly, the bill makes a related conforming change.

EFFECTIVE DATE: January 1, 2027

§§ 8 & 9 — AUTOMOBILE INSURANCE

Makes a technical change to a provision on settlement amounts for totaled vehicles by replacing a reference to the National Automobile Dealers Association's used car guide with J.D. Power's guide to reflect J.D. Power's acquisition of NADA's used car valuation service; eliminates an annual reporting requirement for automobile insurance fraud investigations

Determining Settlement Amount on Totaled Vehicle (§ 8)

By law, when an automobile insurer declares a covered, damaged vehicle a constructive total loss (the repair cost exceeds the vehicle's value), the insurer must calculate the vehicle's value to determine the settlement amount. Current law requires the insurer to use at least the average of the retail values given by two sources: (1) the National Automobile Dealers Association's (NADA) used car guide, or another publicly available automotive industry source the commissioner approves, and (2) one other industry source the commissioner approves for this use.

The bill makes a technical change by substituting J.D. Power's used car guide (or its successor's) for NADA's (J.D. Power acquired the NADA used car valuation service in 2015).

EFFECTIVE DATE: Upon passage

Automobile Insurance Fraud Reporting (§ 9)

The bill eliminates a requirement under current law that insurers annually report, by each March 31, to the insurance commissioner on their automobile insurance fraud investigations during the prior year

and related information. (In practice, the Insurance Department can already access the information through the National Insurance Crime Bureau.)

§ 10 — VIATICAL SETTLEMENT REPORTING

Eliminates the requirement under current law that viatical settlement providers file an annual statement on settled insurance policies with the insurance commissioner

The bill eliminates current law's requirement that viatical settlement providers file an annual statement with the insurance commissioner on specified information about settled insurance policies, such as (1) the total number and life settlement proceeds of policies settled during the immediately preceding calendar year and (2) a breakdown of the information by policy issue year. In practice, viatical settlement providers maintain this data and are legally required to give it to the insurance commissioner upon request.

The bill correspondingly eliminates the penalty of up to $250 per day and $25,000 in the aggregate for failing to file an annual statement.

Viatical settlements involve the sale of a life insurance policy to a third party by a terminally ill insured person.

§ 11 — NOTIFICATION OF FORMULARY CHANGES

Requires health carriers to provide a list of any prescription drugs being removed from a formulary and those covered for the new plan year annually before the plan's open enrollment period; eliminates a current annual reporting requirement for OHS related to prescription drug formulary requirements

The bill requires health carriers (insurers and HMOs) that offer health benefit plans with prescription drug coverage to annually provide a list of (1) any prescription drugs being removed from the plan's formulary (list of covered drugs) and (2) drugs covered for the new plan year. They must do this before the plan's open enrollment period and make the list readily accessible for anyone to review.

Current law generally allows health carriers to remove from a formulary, or move to a higher cost-sharing tier, any covered prescription drug under limited conditions (for example, the U.S. Food and Drug Administration issues a statement questioning the drug's clinical safety or approves the drug for over-the-counter use). The bill

specifies that health carriers may do this during the plan year.

Additionally, the bill eliminates a provision under current law requiring OHS, at least annually, to study the financial impact of the law's prescription drug formulary requirements on the cost of commercial health plans in the state, including those offered and sold on the exchange. Currently, OHS must report the study results for the preceding year to the insurance commissioner and the Insurance and Real Estate Committee.

EFFECTIVE DATE: January 1, 2027

§§ 12 & 13 — EXTERNAL REVIEW PROCESS DEADLINES AND NOTIFICATION

Requires health carriers to notify independent review organizations when their preliminary review of an external adverse determination is complete; starts the clock for a final external review decision notice generally when the independent review organization receives the carrier's notice

Under existing law, a covered person or their representative may ask the Insurance Department for an external review of an adverse determination (a denial of benefits by the insurer). The insurance commissioner assigns an independent review organization (IRO) to review the determination after a preliminary internal review by the health carrier to determine if the request meets certain criteria (for example, if the person was covered under the plan at the time of service).

Existing law requires the IRO to notify the commissioner, health carrier, and covered person (and their representative if applicable) about its decision within certain time frames.

The bill makes several changes to the expedited and external review decision notice deadlines, chiefly changing when the measurement of each deadline for final notice of a decision starts from when the department assigns the review (as under current law) to when the IRO is notified (under the bill). The bill does not change the length of the review, only the start time when the review period begins.

Preliminary Review Completion Notification

The bill requires the health carrier to notify the assigned IRO in writing once its preliminary review is complete. The health carrier already must notify the commissioner, the covered person, and, if applicable, the covered person's representative. For external reviews, existing law requires the carrier's notification within one business day after the review is complete. For expedited external reviews, existing law requires notification on the same day the carrier completes its review.

External Review

Under the bill, for external reviews generally, the IRO must notify the parties (the commissioner, the health carrier, and the covered person and their representative) about its decision within 45 days after it receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Under current law, the IRO must notify the parties within 45 days after the commissioner assigns the review to the IRO.

External Reviews of Experimental Treatment

Under the bill, for external reviews covering experimental treatments, the IRO must notify the parties about its decision within 20 days after it receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Current law measures the 20-day deadline from time of assignment by the commissioner.

Expedited External Review

Under the bill, for expedited external reviews generally, the IRO must notify the parties as quickly as the covered person's condition requires but not later than 48 hours after the IRO receives notice that the health carrier completed the preliminary review and found the request eligible for external review. By law, the IRO has 72 hours to notify the parties if part of the IRO's work period falls on the weekend. Current law measures the 48- and 72-hour deadlines from the time of assignment by the commissioner.

Expedited External Reviews of Certain Urgent Care Requests

Under the bill, for expedited external reviews of certain urgent care requests, the IRO must notify the parties as quickly as the covered person's condition requires but not later than 24 hours after the IRO receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Current law measures the notification deadline from the time of assignment by the commissioner. Under the bill, these urgent care requests include health care services for substance use (or a co-occurring mental disorder) or a mental disorder generally requiring inpatient services.

Expedited External Reviews of Experimental Treatment

Under the bill, for expedited external reviews covering experimental treatment, the IRO must notify the parties as quickly as the covered person's condition requires but not later than five days after the IRO receives notice that the health carrier completed the preliminary review and found the request eligible for external review. Current law measures the notification deadline from the time of assignment by the commissioner.

Notice Requirements

By law, the IRO's decision notice must include, among other things, (1) a general description of the request, (2) the date the IRO conducted the review, (3) the date the IRO made its decision, and (4) the reason for its decision.

Current law requires the IRO's notice to also include the date the commissioner assigned the review to the IRO. The bill instead requires the IRO's notice to include the date the IRO received notice that the carrier completed its preliminary review and found it eligible for external review.

Background — Related Bill

SB 3 (File 447), favorably reported by the Human Services Committee, among other things, generally shortens the time frame in which carriers must make urgent and non-urgent review request decisions.

EFFECTIVE DATE: July 1, 2026

§ 14 — REPORTING AGENT TERMINATIONS

Requires insurers to report agent terminations for cause to the insurance commissioner within 30 days after the termination

Current law requires insurers, upon the insurance commissioner's request, to report the facts related to an agent's termination, including the reason. If insurers terminate an agent for cause, the bill requires them to report it to the commissioner within 30 days after the termination.

§§ 15 & 16 — THIRD-PARTY ADMINISTRATORS

Requires contracts between TPAs and insurers to include a provision requiring the TPA to continue services if the insurer is insolvent or in receivership; prohibits the insurance commissioner from renewing a TPA license until the TPA pays existing law's health and welfare fee; allows insurers to conduct semi-annual reviews of TPAs remotely

Contracts and License Renewals (§ 15)

Existing law requires a TPA to have a written agreement with an insurer or other person using its services ("insurers") and sets provisions the agreement must include, such as the types of insurance the TPA may administer, a statement of activities the TPA must perform on the insurer's behalf, and termination and dispute resolution procedures. The bill requires the agreement to also include a provision requiring the TPA to continue to provide services if the insurer is insolvent or in receivership.

The bill also prohibits the commissioner from renewing a TPA's license unless the TPA pays the health and welfare fee required under existing law (see § 4).

TPA Semi-Annual Reviews (§ 16)

By law, if a TPA administers benefits for more than 100 certificate holders (for example, insureds) on behalf of an insurer, the insurer must conduct a review of the TPA's operations at least semi-annually. The bill eliminates current law's requirement that at least one review be an on-site audit.

§ 17 — CASUALTY CLAIMS ADJUSTERS CONTINUING EDUCATION REQUIREMENT

Allows the commissioner to make regulations to establish continuing education requirements for licensed casualty claims adjusters

The bill allows the commissioner to make regulations under the UAPA to establish continuing education requirements for licensed casualty claims adjusters.

By law, casualty claims adjusters generally investigate, negotiate, and settle losses for an insurance carrier by establishing the facts of the insured's claim during investigation. (They do not adjust claims for life, accident, health, and fire insurance.)

§§ 18-21 — CONNECTICUT INSURANCE GUARANTY ASSOCIATION

Makes changes to CIGA (which generally protects insureds in the state if certain property and casualty insurers fail) to include cybersecurity insurance policies, increase first-party real property coverage and unearned premium maximum claim amounts, and allow certain guaranty association powers and protections, among other things

Cybersecurity Insurance Coverage

The bill expands CIGA authority to include coverage under a cybersecurity insurance policy or endorsement. "Cybersecurity insurance" is generally coverage for losses from data privacy breaches, identity theft, computer viruses, ransomware attacks, cyber extortion, unauthorized information network security intrusions, and similar issues.

Under current law, CIGA covers automobile, homeowners, workers' compensation, and other property and casualty policies. (Separately, the Connecticut Life and Health Guaranty Association covers life and health insurance policies, among other things.)

Covered Claims and Insolvent Insurers

Under CIGA, a covered claim is generally an unpaid claim under an insurance policy issued by an insurer that becomes insolvent. The bill specifies that a covered claim includes a claim under a policy that is later made the responsibility of another insurer (it is allocated, transferred, merged, novated, or assumed) that may or may not be a CIGA member. However, these claims are covered only when:

1. the original insurer does not owe anything on the policy following a transfer;

2. the insurer who assumed the policy is found to be insolvent by a court in their jurisdiction;

3. the claim would have been covered if it had remained the original insurer's responsibility; and

4. if a member insurer transferred the policies to a non-member, that transaction received prior regulatory or judicial approval.

Generally, member insurers are (1) Connecticut-licensed insurers that issue the types of insurance CIGA covers and (2) assessed certain amounts to cover CIGA's claim obligations.

Under the bill, an insolvent insurer is an insurer that (1) was licensed in Connecticut either when the policy was issued or when the covered event occurred and (2) has received a final order of liquidation with a finding of insolvency from a court in their state. Under current law, an insolvent insurer meets the same criteria as above, but could also be the legal successor to the original insurer because of a merger or company division. Current law also states that an insolvent insurer cannot have been found to be insolvent before October 1, 1971.

Maximum Claim Payments

Generally, under current law, CIGA covers claims for most types of losses between $100 and $500,000 arising under policies of insurers determined to be insolvent on or after October 1, 2015 (or up to $400,000 for insurers insolvent before October 1, 2015, and $300,000 for insurers insolvent before October 1, 2007).

The bill removes the $100 minimum and, for first-party real property claims for insurers insolvent after June 1, 2026, requires CIGA to pay up to $1,000,000 for a single occurrence under a commercial or residential policy.

The bill also caps CIGA's payment at $500,000 for all claims under a

cybersecurity insurance policy or endorsement related to a single insured event.

By law, CIGA pays covered claims for certain unearned premiums (the premium paid for a portion of a policy period for which coverage was not received). The bill sets the maximum amount of coverage at $50,000 per policy. Under current law, the maximum is 50% of a policyholder's unearned premium, up to $2,000 per policy.

Association Powers

The bill specifies that CIGA has authority to salvage and subrogate covered claim obligations, as long as it is not named as the insolvent insurer when conferring jurisdiction. (Subrogation is the legal doctrine that allows an insurer that has paid a loss under an insurance policy to "step into the shoes of" its insured and pursue recovery from the at-fault party.) The law already deems CIGA to be the insolvent insurer, allowing it to pay covered claims and receive all the rights of the insurer as if it had not become insolvent.

Additionally, the bill specifically allows CIGA to appoint and direct (1) legal counsel retained under liability insurance policies to defend covered claims and (2) other service providers as needed.

Insurance Guaranty Coverage for Assumption Reinsurance (§§ 19 & 21)

The bill provides guaranty association coverage for policyholders whose policies were assumed by an insurer not licensed in Connecticut when the policies were originally written, with insurance commissioner discretion (see §§ 23 & 24 below).

§§ 22-23 & 25 — NAIC'S ASSUMPTION REINSURANCE MODEL LAW

Implements the NAIC Assumption Reinsurance Model Law, including (1) notice requirements for assumption reinsurance transactions; (2) policyholder rights under assumption reinsurance agreements, including the right to reject the transfer; and (3) the insurance commissioner's discretion when an insurer is in a hazardous financial condition

Assumption Reinsurance

The bill repeals Connecticut's current assumption reinsurance law and replaces it with NAIC model law. Under the bill, an "assumption

reinsurance agreement" completely transfers obligations or risks, or both, of existing in-force insurance contracts from a transferring insurer to an assuming insurer. The assuming insurer becomes directly liable to the policyholders, and the transferring insurer's insurance obligations are extinguished.

Conditions for Transfer

For a transfer to take place under the bill, prior approval is required from the state insurance commissioner and generally both insurers must be licensed in Connecticut. (However, an insurer in Connecticut can assume insurance obligations and risks under a policy issued to policyholders in another state if it is licensed in the other state or that state's regulatory authority approved the assumption.)

In reviewing requests for approval, the commissioner must consider the following factors:

1. the financial condition of the transferring and assuming insurers and the transaction's effect on their financial conditions;

2. the competence, experience, and integrity of the people who control the assuming insurer;

3. the assuming party's plans or proposals for administering the policies subject to the proposed transfer;

4. whether the transfer is fair and reasonable to the policyholders of both companies;

5. whether the notice of transfer to be issued by the insurer (see below) is fair, adequate, and not misleading; and

6. anything else the commissioner deems appropriate.

Insurers domiciled in other states entering into an assumption reinsurance agreement covering Connecticut policyholders must file certain documents with the commissioner, including (1) an assumption certificate and (2) a copy of the notice of transfer and an affidavit that the transaction is subject to substantially similar requirements (as

determined by the insurance commissioner) in the state of domicile of both the transferring and assuming insurer. If the other states do not have these requirements, then the insurer must get the Connecticut insurance commissioner's prior approval and generally comply with the bill's requirements.

Under the bill, the commissioner may approve a transfer apart from the normal requirements if the transferring insurer is in a hazardous financial condition and the transfer is deemed to be in the best interest of the policyholders. (Under state regulation, the commissioner may consider several factors when determining a hazardous financial condition, such as adverse findings in audit reports, operating losses over the past 12 months, and contingent liabilities.)

Notice Requirement

Under the bill, a transferring insurer must send each policyholder notice by first class mail (or personal delivery with acknowledged receipt if the business is a "home service business" for which the insurer's agent collects premiums weekly or monthly). The insurer must also send the notice to its agents or brokers of record for the affected policies.

The notice, which must be filed with the commissioner for prior approval, must include the following:

1. the proposed transfer date;

2. the name, address, and phone number of both the assuming and transferring insurer;

3. the policyholder's right to either consent to or reject the transfer and the procedure and time limit for doing so;

4. a summary of any effect that consenting to or rejecting the transfer will have on the policyholder's rights;

5. a statement that the assuming insurer is licensed in the policyholder's state or otherwise authorized to assume the

business;

6. the name and address of the person at the transferring insurer to whom the policyholder may send a written statement to accept or reject the transfer;

7. the address and phone number of the insurance regulatory official in the state where the policyholder lives so that the policyholder may contact the official for further information on the assuming insurer's financial condition;

8. financial data for the transferring and assuming insurers, including ratings for the past five years, if available (and, if any year's ratings are unavailable, disclosure of the unavailability), and balance sheets for the past three years, among other things; and

9. an explanation of the reason for transfer.

The notice of transfer must include a pre-addressed, postage-paid response card that a policyholder may return as a written statement of transfer acceptance or rejection.

The bill authorizes the commissioner to adopt regulations to set the notice's form.

Rejecting Transfer

Under the bill, policyholders may reject transfers in writing by using the response card or other written means, but paying a premium to the assuming insurer within 24 months after receiving a notice of transfer indicates that the policyholder accepted the transfer. However, for a premium payment to constitute acceptance of a transfer, the insurer's premium billing notice must state that premium payment constitutes acceptance. The premium billing notice must also include a way for the policyholder to pay the premium while reserving the right to reject the transfer.

If the policyholder has not rejected or consented within two years

after the initial notice, the transferring insurer must send the policyholder a second and final notice. If there is no policyholder response in the month following the final notice, the policyholder is deemed to consent to the transfer.

Current Law

Under current law, Connecticut allows for assumption reinsurance agreements (also known as "bulk reinsurance") that the commissioner can approve or deny, with no provision for notifying policyholders (CGS § 38a-66). Assumption reinsurance agreements become effective 20 days after they are filed with the commissioner, unless disapproved. The commissioner must deny assumption reinsurance requests before that deadline if he finds that:

1. the agreement is unfair and inequitable to any insurer or policyholder involved,

2. the agreement would reduce services to the policyholders of involved insurers,

3. the agreement lacks adequate provisions to make the reinsurer liable to the original insured for any loss or damage that occurs under the policy's original terms,

4. the agreement does not adequately require the assuming insurer to give policyholders a certificate reflecting the assumption of liability,

5. the assuming reinsurer is not authorized to transact the type of insurance in this state,

6. the assuming reinsurer will not appoint the commissioner as its irrevocable attorney for service of process when policies or claims under the reinsurance are in force,

7. the agreement would decrease competition or create a monopoly, or

8. the proposed reinsurance has other reasonable objections.

The commissioner must notify the involved insurers in writing of the reasons for the denial.

§ 24 — SURPLUS LINES BROKER REPORTING

Allows the commissioner, with limited exceptions, to require surplus lines brokers to annually report information on surplus lines policies issued in the state, such as covered real property locations and premiums and the number of policies renewed in the prior year

The bill allows the commissioner to require surplus lines brokers to annually report to him on the (1) number and types of surplus lines policies issued, (2) locations of any covered real property and the total premiums policyholders paid under those policies, and (3) number of policies renewed in the prior year.

The bill specifies that it does not prevent the commissioner from requesting and obtaining any additional information under the state's insurance laws.

By law, the insurance commissioner must maintain, publish, and make available to surplus lines brokers a list of insurance lines that are generally unavailable from licensed insurers. The bill eliminates current law's requirement that an insured and broker, when an insured procures or renews an insurance line that did not appear on this list, first make a diligent effort to obtain the insurance from a licensed insurer and document specified information about the policy. Lastly, the bill exempts from its requirements (1) flood insurance policies procured under the National Flood Insurance Program, (2) insurance policies procured for an "exempt commercial purchaser" as defined under federal law (see BACKGROUND), and (3) insurance policies where brokers seek to procure or place them through unaffiliated wholesale surplus lines.

BACKGROUND

Exempt Commercial Purchaser

The federal Nonadmitted and Reinsurance Reform Act (P.L. 111-203) defines an exempt commercial purchaser as someone that (1) employs or retains a qualified risk manager to negotiate insurance coverage; (2) has, in the preceding year, paid over $100,000 in aggregate nationwide commercial property and casualty insurance premiums; and (3) meets

at least one of the following requirements:

1. has a net worth over $29 million;

2. generates over $72 million in annual revenues;

3. employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group that employs more than 1,000 employees;

4. is a nonprofit organization or public entity that generates at least $43 million in annual budgeted expenditures; or

5. is a municipality with a population over 50,000.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11 Nay 2 (03/12/2026)