OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

SpecialReport

2026 Acts Affecting Insurance

By: Michelle Kirby, Senior Legislative Attorney

June 16, 2026 | 2026-R-0094

Notice to Readers

This report provides summaries of new laws (public acts and special acts) significantly affecting commercial insurance enacted during the 2026 regular legislative session. OLR's other Acts Affecting reports, including Acts Affecting Housing and Real Estate and Acts Affecting Health Professionals and Institutions, are, or will soon be, available on OLR's website.

Each summary indicates the public act (PA) or special act (SA) number. Not all provisions of the acts are included. The report does not include vetoed acts unless the veto was overridden. Complete summaries of public acts are, or will soon be, available on OLR's website.

Readers are encouraged to obtain the full text of acts that interest them from the General Assembly's website or the Connecticut State Library.

Cover image by Iftikharalam from Vecteezy.com and Canva.com

Table of Contents

Health Insurance

Anti-Steering Clauses

A new law specifically allows health carriers and health plan administrators to use utilization management provisions to encourage enrollees to use certain hospitals and health systems (such as centers of excellence) by expanding the definition of anti-steering clauses (PA 26-68, § 218, effective October 1, 2026).

Biomarker Testing

A new law requires the Department of Social Services (DSS) commissioner, by October 1, 2026, to report to the Human Services Committee on (1) prior authorization requirements for Medicaid coverage of biomarker testing, including their impact on beneficiary access, and (2) how many received approval for Medicaid coverage for this testing in FY 26.

Existing law requires DSS, to the extent federal law allows, to cover medically necessary biomarker testing to diagnose, treat, manage, or monitor a beneficiary's medical condition. Biomarker testing is the analysis of a patient's tissue, blood, or other biospecimen for biomarkers (for example, genes or proteins) that may indicate the presence of a disease or condition, help plan treatment, or determine how well a treatment is working (PA 26-146, § 3, effective upon passage).

Connecticut Option

A new law allows the Office of Policy and Management (OPM) to study, and, under certain conditions, pursue federal approval for, a Connecticut Option program, which is a plan to lower health care coverage costs and expand health care coverage. The study must review proposed design elements, such as provider reimbursement methodologies, value-based or performance-based contracting arrangements, and any state-specific premium assistance programs or risk stabilization programs. OPM must file an interim report with various legislative committees by January 15, 2027, and a final report with these committees by January 31, 2028. If the OPM secretary determines the program is feasible, the act allows him to direct the relevant state agency to develop applicable federal waivers (PA 26-68, § 453, effective upon passage).

Health Insurance Benefit Mandates

Starting January 1, 2027, a new law generally requires certain individual and group health insurance policies to provide coverage for:

1. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) treatment, including the use of intravenous immunoglobulin therapy;

2. prosthetic devices designed exclusively for athletic purposes, at least equivalent to the coverage Medicare provides for these devices, including medically necessary repairs and replacements;

3. scalp cooling systems used in connection with chemotherapy, at least equivalent to the coverage Medicare provides for them, and additionally applies to individual and group health insurance policies for specified disease coverage (a "scalp cooling system" is any device designed and intended for repeated medical use to cool the human scalp to prevent or reduce hair loss due to chemotherapy); and

4. infertility diagnosis and treatment under an expanded definition of "infertility" that, among other things, establishes various ways in which infertility can be determined (PA 26-33, effective January 1, 2027).

Health Insurance Coverage for Retired Police and Firefighters

A new law requires the state comptroller to study health insurance coverage for retired police officers and firefighters, including an assessment of any gaps in, absence of, or diminished coverage for those who retired due to an illness or injury. The comptroller must submit a report on the study's findings to the Labor and Public Employees Committee by January 1, 2027 (PA 26-12, § 50, effective upon passage).

Health Insurance Coverage for Survivors of Volunteer Firefighters, State Marshals, Correction Officers, and Investigators

This year, the legislature passed a law extending nonstate public employer "partnership plan" health care coverage to the survivors of certain unpaid volunteer firefighters and requires non-state public employers to apply for partnership plan coverage for these survivors whether or not the first responder or unpaid volunteer firefighter was an employee of the nonstate public employer at the time of death. It requires the non-state public employer the responder or firefighter provided services to at the time of death to apply for coverage.

The act also requires the state comptroller, with approval from the attorney general and the insurance commissioner, to allow the surviving spouse and dependent children of a state marshal,

correction officer, investigator, or unpaid volunteer firefighter to participate in the state employee health insurance plan (PA 26-12, §§ 11 & 12, effective upon passage).

ICHRA Tax Credit Related to the Health Insurance Exchange

A new law establishes a tax credit for qualified small businesses that offer employees an Individual Coverage Health Reimbursement Arrangement (ICHRA) through the state's health insurance exchange. The credit may be claimed for no more than two consecutive years against the state insurance and health care center taxes, corporation business tax, or income tax (excluding withholdings generally). To qualify, a small business (with fewer than 50 employees in the state) must have adopted an ICHRA instead of a traditional employer-provided health insurance plan. The available credit cannot exceed $1,000 per covered employee and is capped at $5 million in total for any income or taxable year (PA 26-68, § 263, as amended by PA 26-76, § 85, effective upon passage and applicable to income and taxable years starting on and after January 1, 2026).

Infusion and Injection Services

This session, the legislature passed various measures establishing requirements for the Insurance Department, hospitals and health systems, and health carriers related to infusion and injection services. First, a new law requires hospitals and health systems to give patients written notification at the time of scheduling that it may cost patients more to use infusion or injection services at hospital-based outpatient infusion centers located outside the hospital campus than if the patient received them at a nonhospital-based infusion center. This new law similarly requires health carriers and utilization review companies (when preauthorizing or precertifying these services provided at infusion centers) to give the insured the same information regarding the cost difference by written or electronic notification (PA 26-68, §§ 215 & 216, as amended by PA 26-76, § 35, effective January 1, 2027).

Relatedly, the new law also directs the Insurance Department, in consultation with the office of the healthcare advocate and within available appropriations, to study (1) potential ways to lower the cost of infusion and injection services provided at hospital-based off-campus outpatient facilities; (2) appropriate patient protections for stop-loss insurance policies used with self-funded employee health benefit plans; and (3) surprise bills for ground ambulance services (PA 26-68, § 217, as amended by PA 26-76, § 41, effective upon passage).

Paraeducators Health Insurance Subsidy

New legislation makes permanent two health care subsidy programs for paraeducators employed by school boards and expands the programs to include paraeducators at charter schools. The legislation also requires the comptroller to report to the Education and Appropriations committees

by January 1, 2027, on the cost of expanding the programs for paraeducators at charters (PA 26-149, §§ 6 & 7, effective July 1, 2026, except the cost study provision is effective upon passage).

State Immunization Standards

In response to recent changes in federal Centers for Disease Control and Prevention (CDC) vaccine standards, the legislature enacted a law requiring the Department of Public Health (DPH) to establish immunization standards of care for all Connecticut residents, instead of only children and adolescents as under prior law. In developing these standards, it allows DPH to consider recommended vaccine schedules from several medical professional organizations, such as the American Academy of Pediatrics and American Academy of Family Physicians.

Among other things, the new law also requires (1) the Connecticut Vaccine Program to give all children's vaccines included under DPH's standard of care, instead of only those recommended by the CDC; (2) establishes, within available appropriations, a new DPH-administered Vaccines for Adults Program that gives vaccines at no cost to under- and uninsured adults; (3) requires certain health insurance policies to cover immunizations included in DPH's standards of care; and (4) allows licensed pharmacists to give vaccines listed in DPH's immunizations standards of care, instead of only CDC-recommended vaccines, for adults and certain minors.

Additionally, the new law expressly provides that the state's Religious Freedom Restoration Act does not apply to school and child care facility immunization requirements (PA 26-3, various effective dates).

Insurance Industry

External Review Process Deadlines and Notification

Under existing law, a covered person 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 to review the determination after a preliminary internal review by the health carrier. A new law requires health carriers to notify independent review organizations when their preliminary review of an external adverse determination is complete. By law, final external reviews must also be completed within certain timeframes based on the type of review (for instance, they may be expedited based on the covered person's medical needs). The new law also starts the clock for a final external review decision notice generally when the independent review organization receives the carrier's notice, instead of when the organization is assigned the review by the commissioner as under prior law (PA 26-69, §§ 12 & 13, effective July 1, 2026).

Infirmaries Operated by Educational Facilities

A new law allows an infirmary operated by an educational institution to provide care to dependent family members of students, faculty, and employees when these family members are enrolled in the institution's health plan. Previously, these facilities provided evaluation and treatment for routine health problems and, in some cases, short-term overnight accommodations (for example, when someone is recovering from surgery or requires observation) only for students, faculty, and employees (PA 26-13, § 1, effective October 1, 2026).

Insurance Fund

By law, domestic insurers and HMOs must pay an annual general assessment to the Insurance Fund to cover the expenses of the Insurance Department, among other things. A new law adds the Office of the Behavioral Health Advocate to the list of entities the assessment covers, and correspondingly adds it to calculations and statements the department uses in setting the fee. The law also delays several reporting dates in the general assessment process and makes changes to the fee's installment structure, such as increasing the first payment and correspondingly decreasing the final payment, and delaying some of the installment due dates (PA 26-69, § 5, effective October 1, 2026).

Another new law requires the assessment to cover the costs of OPM, rather than the Office of Health Strategy (OHS), that are appropriated from the insurance fund (as part of its overall elimination of OHS and general transfer of OHS's duties to other agencies) (PA 26-68, §§ 144 & 145, effective July 1, 2026).

Insurance License Suspension and Revocation Notices

By law, the commissioner can revoke or suspend insurance licenses for cause following notice and a hearing. A new law allows the insurance commissioner to deliver revocation or suspension notices by the provided email address of the (1) entity's (firm, association, or corporation) designated primary contact person or (2) individual licensee or registrant, as applicable (PA 26-69, §§ 2 & 3, effective October 1, 2026).

Objection Process for Health and Welfare Fee

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. A new law establishes an objection process for the health and welfare fee, allowing domestic insurers, HMOs, TPAs, and exempt insurers to submit objections to the proposed fee annually, by December 20 to

the insurance commissioner. The commissioner must then submit a final statement to the objector, by January 1, that includes any adjustments to the fee he deems necessary, and insurers must pay the final fee by February 1 (PA 26-69, § 4, effective October 1, 2026).

Reporting Agent Terminations

Prior law required insurers, upon the insurance commissioner's request, to report the facts related to an agent's termination, including the reason. If insurers terminates an agent for cause, a new law requires them to report it to the commissioner within 30 days after the termination (PA 26-69, § 14, effective October 1, 2026).

Third-Party Administrators

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 (1) the types of insurance the TPA may administer, (2) a statement of activities the TPA must perform on the insurer's behalf, and (3) termination and dispute resolution procedures. A new law requires the agreement to also include a provision requiring the TPA to continue to provide services if the insurer is insolvent or in receivership. Additionally, the act also prohibits the commissioner from renewing a TPA's license unless the TPA annually (1) reports to the insurance commissioner on the number of enrollees for which it provides health benefits and (2) pays the health and welfare fee as assessed by the commissioner.

Relatedly, if a TPA administers benefits for more than 100 certificate holders (for example, insureds) on behalf of an insurer, state law requires the insurer to review the TPA's operations at least semi-annually. The new law also eliminates the requirement that at least one review be an onsite audit (PA 26-69, §§ 15 & 16, effective October 1, 2026).

Medicaid

Covered Connecticut

DSS administers Covered Connecticut, which provides subsidized health insurance coverage for eligible individuals. This year, the legislature made changes to the program such as narrowing the program's scope by allowing, rather than requiring, it to provide dental and nonemergency medical transportation services. Prior law also required DSS to provide premium and cost-sharing subsidies sufficient to ensure fully subsidized coverage. The new law narrowed this requiring to only apply to premium coverage.

Separately, the Covered Connecticut program, in practice, is partially federally funded through a Section 1115 Medicaid demonstration waiver and DSS must apply to the federal Centers for Medicare and Medicaid Services (CMS) to periodically renew or make changes to the waiver. Under a new law, if CMS denies or fails to approve the Covered Connecticut Section 1115 waiver by July 1, 2027, DSS must either (1) seek any necessary federal approvals to establish a basic health program and take all necessary actions to maximize federal funding or (2) take necessary steps to continue Covered Connecticut as a state-funded program, starting January 1, 2028. The new law also requires DSS to report every six months during 2027 and 2028 to describe its activities and planning to sustain Covered Connecticut as an affordable coverage option (PA 26-68, §§ 454, 455 & 462, various effective dates).

Medicaid Provider Audits

A new law limits the circumstances under which DSS can determine overpayment by extrapolation when auditing Medicaid provider claims if the total net amount of the extrapolated overpayment calculated from a statistically valid sampling and extrapolation method exceeds 2.75%, instead of 1.75%, of total claims paid to the provider for the audit period. By law, extrapolation means determining an unknown value by projecting the results of a review of a sample of claims to the entire population of claims from which the sample was drawn (PA 26-143, effective October 1, 2026).

Medicaid Rate Increase for Family Planning Clinics

This session, the legislature required the DSS commissioner to amend the Medicaid state plan to increase reimbursement rates for licensed family planning clinics and give at least $500,000 in Medicaid state share funds to do so. The commissioner must use funds appropriated for family planning services for FY 27 for this purpose (PA 26-68, § 448, effective July 1, 2026).

Medicaid Rate Reviews

A new law requires the DSS commissioner to create a five-year process for regularly and predictably reviewing Medicaid reimbursement rates. The process must (1) examine Medicaid provider reimbursements; (2) benchmark the rates to those for the same services paid by Medicare, when possible and under available appropriations; and (3) allow for public comment. It also requires the commissioner to (1) use this new process starting by January 1, 2027, and (2) annually report on it, starting by January 15, 2028, to the Appropriations and Human Services committees (PA 26-146, § 1, effective July 1, 2026).

Another new law requires the commissioner, when reviewing Medicaid rates, to include rates required to be studied under the Medicaid rate study established under PA 23-186 with no

corresponding (1) Medicare rate for the same health care service or (2) average five-state rate benchmark included in the Medicaid rate study. The law also sets comparison requirements if any state within the Medicaid rate study's five-state rate benchmark group (Maine, Massachusetts, New Jersey, New York, and Oregon) has a corresponding rate for the same or a substantially similar health care service.

Additionally, when setting Medicaid behavioral health service reimbursement rates, this law requires the commissioner to include medication administration services by licensed home health care agencies to people with psychiatric diagnoses under a care plan that is (1) developed and supervised by a licensed behavioral health clinician or prescriber and (2) overseen by the state's behavioral health administrative services organization (currently Carelon Behavioral Health CT) (PA 26-68, § 450, effective July 1, 2026).

Medicaid Value-Based Payment Working Group

A new law creates a Medicaid Value-Based Payment Working Group to collaboratively design, evaluate readiness for, and recommend scalable, voluntary, value-based payment models for the Medicaid population. The group's members must be appointed by the DSS commissioner and include representatives of hospitals, physicians, federally qualified health centers, behavioral health care providers, health carriers or managed care organizations participating in Medicaid, consumer advocates, and any other stakeholders the commissioner deems appropriate. The working group must submit recommendations to the Human Services and Public Health committees by January 1, 2028, including opportunities for implementing a pilot (PA 26-68, § 370, effective July 1, 2026).

Personal and Commercial Risk Insurance — Premium Billing Notices

A new act generally allows an insurer (or its agent) to send premium billing notices for personal or commercial risk insurance electronically at least 30 days before the policy's renewal or anniversary date if the insurer and insured agree. Under the new act and existing law, (1) the insurer can provide notice by mail subject to the same timeframe as above and (2) these provisions apply to policies costing less than $50,000 for the preceding annual policy period. For personal risk policies, the act additionally requires that premium billing notices state (1) that the insurer will give a reasonable explanation for a premium increase within 20 days after an insured asks for one in writing and (2) the insurer's contact information for receiving these requests (PA 26-69, § 7, effective January 1, 2027).

Transitional Health Care Premium Assistance

A new law requires the OPM secretary, by October 1, 2026, to design a plan for transitional health care premium assistance to offset 2027 premium and cost-sharing increases on Access Health CT. The plan must include a state health care premium subsidy to enable an eligible enrollee to get an affordable health plan on Access Health CT by December 31, 2027. The law also authorizes OPM to design a plan to provide transitional health care premium assistance funded from the Federal Cuts Response Fund established under state law or other funding sources (PA 26-68, § 453, effective upon passage).

Pharmacy and Prescription Drug

Generic Drugs and Biosimilar Products

This session, the legislature passed a law generally requiring that health benefit plans make certain generic drugs and biosimilar products available at a lower cost than the reference drug or product already on the formulary approved under the health benefit plan. For this requirement to apply, the generic drug or biosimilar product must (1) be FDA approved, (2) be marketed pursuant to that approval, and (3) have a lower net drug cost than the reference drug or product. Additionally, the new law prohibits health benefit plans from restricting enrollees from using their chosen pharmacy network to get generic drugs or biosimilar products, unless the reference drug or product is similarly restricted (PA 26-68, §§ 460 & 461, effective January 1, 2027).

Notification of Formulary Changes

Under a new law, health carriers (insurers and HMOs) that offer health benefit plans, on or after January 1, 2027, with prescription drug coverage must annually (before the plan's open enrollment period) 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. The law also removes the Office of Health Strategy's annual study requirement on the financial impact of prescription drug formulary requirements on the cost of commercial health plans (including exchange plans) in the state (PA 26-69, § 11, effective January 1, 2027).

Pharmacists' Compensation

A new law generally requires health carriers, TPAs, and pharmacy benefits managers (PBMs) covering benefits under a health benefit plan in Connecticut to reimburse pharmacists for covered clinical services and include them in reimbursement processes and provider networks, subject to reasonable participation, credentialing, and contracting standards these entities may set. Under the act, a "covered clinical service" is any service or procedure within the scope of the pharmacist's license and covered under the health benefit plan's terms when done by any other licensed health

care provider. The act prohibits a health carrier, TPA, or PBM from denying reimbursement for any clinical service solely because it (1) is provided by a pharmacist within their scope of practice and license and (2) would otherwise be eligible for reimbursement if provided by a physician, physician assistant, or advanced practice registered nurse (PA 26-47, § 2, effective January 1, 2028).

Property and Casualty Insurance

Automobile Insurance for Volunteer Drivers

This session, the legislature passed a law prohibiting auto insurers from raising rates on or refusing to renew a policy solely because the person drives as a volunteer for nonprofit or charitable organizations (PA 26-102, § 2, effective January 1, 2027).

Automobile Insurance Fraud Reporting

A new law eliminates a requirement that insurers annually report to the insurance commissioner on their automobile insurance fraud investigations during the prior year (PA 26-69, § 9, effective October 1, 2026).

Casualty Claims Adjusters Continuing Education Requirement

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. A law passed this session allows the commissioner to adopt regulations to establish continuing education requirements for these adjusters (PA 26-69, § 17, effective October 1, 2026).

Connecticut Insurance Guaranty Association

By law, the Connecticut Insurance Guaranty Association (CIGA) covers policy holders if their insurer (for automobile, homeowners, workers' compensation, and other property and casualty policies) becomes insolvent. A new law makes several changes to CIGA, including, among other things, (1) expanding CIGA's coverage to include cybersecurity insurance policies (up to $500,000 of damage); (2) increasing first-party real property coverage (up to $1 million of damage) and unearned premium maximum claim amounts (up to $50,000 per policy); and (3) removing the minimum $100 amount for covered claims (PA 26-69, §§ 18-21, effective October 1, 2026).

Totaled Automobile Settlement Amount

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. Prior law required 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. A new law substitutes J.D. Power's used car guide (or its successor's) for NADA's in these calculations (PA 26-69, § 8, effective upon passage).

Other Insurance Lines-Of-Business

Assumption Reinsurance

This session, the legislature repealed Connecticut's assumption reinsurance law and replaced it with a National Association of Insurance Commissioners' model law. Assumption reinsurance generally entails a complete transfer of existing in-force insurance contracts (including property, casualty, life, health, accident, surety, title, and annuity business) from a transferring insurer to an assuming insurer that becomes directly liable to the policyholders. The new law (1) creates notice requirements for insurers before assumption reinsurance transactions, including disclosing certain financial data; (2) establishes policyholder rights under assumption reinsurance agreements, including the right to reject the transfer; and (3) gives the insurance commissioner discretion to authorize a transfer when an insurer is in hazardous condition and a transfer would be beneficial to policyholders (PA 26-69, §§ 22, 23 & 25, effective October 1, 2026).

Liability Insurance Risk Pooling by Nonprofits

A new law requires the insurance commissioner, within available appropriations, to:

1. study the feasibility of (a) allowing nonprofits to pool their liability insurance policies; (b) establishing a captive insurance company, risk management agency, or a program to insure the pool's risk; and (c) establishing any other insurance program to address state-contracted nonprofits' needs;

2. develop a proposed plan to establish the company, agency, or program described above and a related financial analysis to assess the appropriate structure of the company, agency, or program to ensure its financial and operational viability; and

3. report on the study, proposed plan, and financial analysis to the legislature, by November 1, 2026 (PA 26-47, § 1, effective upon passage).

Life Insurance — Viatical Settlement Reporting

Viatical settlements involve the sale of a life insurance policy to a third party by a terminally ill insured person. A new law eliminates a requirement (and associated penalties for noncompliance) that viatical settlement providers file an annual statement with the insurance commissioner on specified information about settled insurance policies, including information about policies settled

within five years of their issuance. This includes information such as (1) the total number and life settlement proceeds of policies settled during the last calendar year; (2) a breakdown of the information by policy issue year; and (3) the names of the insurance companies and brokers involved in those policies (PA 26-69, § 10, effective October 1, 2026).

Long-Term Care Insurance

This session, the legislature passed a law creating new long-term care (LTC) insurance-related requirements. Among other things, the law (1) establishes new annual reporting requirements for insurers and the Insurance Department on LTC policy losses; (2) authorizes the insurance commissioner to investigate and take disciplinary action against LTC insurers that violate state LTC insurance laws; and (3) allows the insurance commissioner to report to the legislature on the feasibility and effect of certain insurer requirements on LTC insurance access (such as requiring LTC insurers to allow policyholders to cancel their insurance and get a refund for all premiums they paid since the start of the policy whenever the insurer files for a rate increase that exceeds the inflation rate) (PA 26-93, effective July 1, 2026).

Surplus Lines Broker Reporting

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 in the state. A new law eliminates the requirement that an insured and broker, for items not on this list, make a diligent effort to fully acquire insurance through authorized insurers in this state (and therefore allows coverage from nonadmitted insurers, even if an authorized insurer could provide coverage).

The new law also allows the commissioner to require surplus lines brokers to annually report to him on certain policy information (such as the number and types of surplus lines issued), and exempts certain forms of insurance from the new reporting requirement (such as flood insurance bought through the National Flood Insurance Program) (PA 26-69, § 24, effective October 1, 2026).

Workers Compensation

Enhanced Workers' Compensation Benefits for Health Care Providers and Teachers Assaulted at Work

A new law allows certain teachers, health care providers, and related employees to receive enhanced workers' compensation benefits if they are unable to work because of a physical or negligent assault upon them while performing their work duties. More specifically, it qualifies them to receive a workers' compensation benefit that equals 100% of their gross (rather than net) average weekly earnings, with no cap on the benefit amount, plus their reasonable expenses for

medical or other services needed due to the assault, and any lost wages due to an absence for a court appearance connected to the assault (PA 26-12, § 1, effective October 1, 2026).

Portal-to-Portal Workers' Compensation for Public Works Department Employees

This session, the legislature extended "portal-to-portal" workers' compensation coverage to public works department employees in three situations: (1) when they are subject to emergency calls while off duty, (2) when they are responding to a direct order to appear at work when nonessential employees are excused from working, or (3) after working two or more mandatory overtime shifts on consecutive days. With "portal-to-portal" coverage, an injury that occurs while the employee is traveling directly between his or her home and workplace is deemed to have occurred in the course of the employee's employment, making him or her eligible to receive workers' compensation benefits for the injury (PA 26-12, § 7, effective October 1, 2026).

Second Injury Fund

This year, the legislature limited the amount insurers may be reimbursed from the Second Injury Fund (SIF) to a three-year period. By law, insurers may transfer liability for certain workers' compensation claims to SIF and request reimbursement for certain benefits they already paid out (for example, claims paid out to cover an employee's lost wages from other companies not covered by the insurer).

The law specifies that SIF may only reimburse an insurer within two years from when the insurer paid the benefits to the employee. However, this allowed reimbursement for benefits from before this two-year deadline (for example, making a lump sum restitution payment to cover underpaid benefits for an extended period of time). Therefore, the law limits the amount that SIF reimburses to a three-year period (and therefore makes insurers liable for any additional amounts owed to an employee outside that period) (PA 26-94, § 8, effective July 1, 2026).

Task Force to Study Undue Delay in Workers' Compensation Claims by Police Officers and Firefighters

This session, the legislature created a task force to study causes of undue delay in workers' compensation claims made by police officers and firefighters. It must examine delays caused by administrative processing, medical provider availability and schedule limitations, and insurer authorization requirements, and report to the Labor and Public Employees Committee by January 1, 2027 (SA 26-34, effective upon passage).

Miscellaneous

Benchmarks for Health Care Quality and Cost and Hospital Payment Growth and Primary Care Spending Targets

A new law transfers to the OPM secretary the OHS commissioner's duties to develop and assess compliance with benchmarks for health care quality and cost growth and primary care spending targets. (The new law does so as part of its overall elimination of OHS and general transfer of OHS's duties to other agencies, see below.) The new law makes several changes to this process and establishes additional responsibilities for the OPM secretary in this role, including those related to developing and adopting hospital payment growth benchmarks.

Regarding the annual health care cost growth benchmark, the new law sets a statutory benchmark of 3.9% for 2028 through 2032 and requires the secretary to develop and adopt annual benchmarks for 2033 and every five years after that, using a formula the new law prescribes. It generally maintains existing law's requirements regarding health care quality benchmarks but creates a new method the secretary must use to develop and adopt primary care spending targets.

Among other things, the new law also requires the secretary to adopt a (1) hospital payment growth methodology that considers certain factors and (2) revised methodology for assessing compliance with the health care cost growth benchmark. Provider entities and hospitals that exceed the applicable benchmark may develop and implement a cost growth benchmark plan to achieve compliance and may be subject to penalties for failing to do so (PA 26-68, §§ 364-369, and as amended by PA 26-76, §§ 26, 27 & 95-98, generally effective July 1, 2026).

Direct-to-Consumer Genetic Testing Companies

A new law (1) gives consumers a property right and exclusive control over their biological samples that are given to direct-to-consumer genetic testing companies and their results and (2) requires these companies to disclose certain policies and procedures to consumers and get a consumer's consent for various uses of their genetic data. Among other things, the new law prohibits a company from disclosing a consumer's genetic data to someone who in the ordinary course of business, offers health, life, or long-term care insurance or provides information to an insurer, health care center, or fraternal benefit society for underwriting or rating risks.

Under this new law, "direct-to-consumer genetic testing companies" are individuals or entities that, in the ordinary course of business in Connecticut, offer genetic testing directly to a consumer or collect, use, or analyze genetic data given by a consumer. These are not licensed health care

services providers who, within the scope of their practice, order genetic testing for a medical purpose (PA 26-64, §§ 17-19, effective October 1, 2026).

Electronic Service of Legal Process

By law, the insurance commissioner acts as agent for service of legal process on various insurance companies and related entities. A new law allows the commissioner, upon receipt of the legal process, to send a copy of it electronically to the person to be served, instead of only by registered or certified mail as under prior law (PA 26-69, § 1, effective October 1, 2026).

Office of Health Strategy Eliminated

A new law eliminates OHS and generally transfers its powers, duties, and functions to DPH, OPM, DSS, and the Office of the Healthcare Advocate. It eliminates certain OHS functions without transferring them to another agency, such as an annual study on how certain laws (including limitations on removing drugs from formularies) impact the costs of health insurance plans.

Under existing law, domestic insurers and HMOs pay an annual assessment to the Insurance Department to cover the expenses of certain agencies and programs. The new law requires the assessment to cover the costs of OPM, rather than OHS, that are appropriated from the insurance fund, and makes related conforming changes (PA 26-68, §§ 68-161 & 364-369, and PA 26-76, §§ 76 & 96, generally effective July 1, 2026).

Sourcing Insurance Premiums Tax Revenue to Municipalities

Starting with FY 26, the law requires the Department of Revenue Services commissioner to track and record the source of certain state taxes to accurately and fairly attribute the revenue from these taxes to municipalities. This session, the legislature additionally requires the commissioner to track and record the source of insurance premiums taxes for this same purpose. By law, taxpayers paying these covered taxes must provide disaggregated information and any other data the commissioner requests to carry out this law (PA 26-68, § 273, effective July 1, 2026).

Terrorism Insurance Requirement for Condominiums

A new law eliminates the 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 (PA 26-69, § 6, effective upon passage).

Unclaimed Property

State law requires that certain institutions, including insurance companies, turn over unclaimed property to the state treasurer by certain deadlines. By law, unclaimed funds held by an insurance company for more than three years may become unclaimed property if a person other than the insured or annuitant is owed the money, and the company does not have that person's address. The three-year timeline generally starts when the money became due and payable under any matured or terminated life or endowment insurance policy or annuity contract.

A new law specifies that an automatic premium loan provision or other non-forfeiture provision in an insurance policy does not prevent the policy from being deemed matured or terminated if the (1) insured died or (2) insured or a beneficiary have become entitled to the proceeds before the depletion of the policy's cash surrender value (PA 26-94, § 2, effective July 1, 2026).

MK:co