House of Representatives

General Assembly

File No. 363

January Session, 2025

Substitute House Bill No. 7039

House of Representatives, March 31, 2025

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE RETURN OF HEALTH CARE PROVIDER PAYMENTS, ESTABLISHING A WORKING GROUP TO STUDY PHARMACIST COMPENSATION FOR ADMINISTERING CERTAIN SERVICES, REVISING THE DEFINITION OF CLINICAL PEER AND CONCERNING THE CONNECTICUT UNFAIR INSURANCE PRACTICES ACT.

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

Section 1. Subsection (c) of section 38a-479b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(c) (1) No contracting health organization shall cancel, deny or demand the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than **[**eighteen**]** twelve months after the date of the receipt of a clean claim, except if:

(A) Such organization has a documented basis to believe that such claim was submitted fraudulently by such provider;

(B) The provider did not bill appropriately for such claim based on the documentation or evidence of what medical service was actually provided;

(C) Such organization has paid the provider for such claim more than once;

(D) Such organization paid a claim that should have been or was paid by a federal or state program; or

(E) The provider received payment for such claim from a different insurer, payor or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy. Such provider shall have one year after the date of the cancellation, denial or return of full or partial payment to resubmit an adjusted secondary payor claim with such organization on a secondary payor basis, regardless of such organization's timely filing requirements.

(2) (A) Such organization shall give at least thirty days' advance notice to a provider by certified mail, return receipt requested, electronic mail to such electronic mail address designated by such provider or facsimile of the organization's cancellation, denial or demand for the return of full or partial payment pursuant to subdivision (1) of this subsection.

(B) If such organization demands the return of full or partial payment from a provider, the notice required under subparagraph (A) of this subdivision shall disclose to the provider (i) the amount that is demanded to be returned, (ii) the claim that is the subject of such demand, and (iii) the basis on which such return is being demanded.

(C) Not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision, a provider may appeal such cancellation, denial or demand in accordance with the procedures provided by such organization, which shall include, but not be limited to, an electronic appeal process. If any such organization fails to notify

the provider of such organization's determination of such appeal not later than ten business days after receipt of such appeal from such provider, such appeal shall be construed in favor of such provider. Any demand for the return of full or partial payment shall be stayed during the pendency of such appeal.

(D) If there is no appeal or an appeal is denied, such provider may resubmit an adjusted claim, if applicable, to such organization, not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision or the denial of the appeal, whichever is applicable, except that if a return of payment was demanded pursuant to subparagraph (C) of subdivision (1) of this subsection, such claim shall not be resubmitted.

(E) A provider shall have one year after the date of the written notice set forth in subparagraph (A) of this subdivision to identify any other appropriate insurance coverage applicable on the date of service and to file a claim with such insurer, health care center or other issuing entity, regardless of such insurer's, health care center's or other issuing entity's timely filing requirements.

Sec. 2. (*Effective from passage*) (a) Not later than July 1, 2025, the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, or their designees, shall convene a working group to study and make recommendations for legislation related to the compensation of pharmacists licensed under chapter 400j of the general statutes, who provide certain health care services, including, but not limited to, vaccine administration, HIV-related tests, influenza-related tests and the prescribing of contraceptive devices or products approved by the federal Food and Drug Administration. For the purposes of this section, (1) "chain pharmacy" means any community pharmacy that is publicly traded or has not less than six stores located in this state, (2) "HIV-related test" and "influenza-related test" have the same meanings as provided in section 20-633f of the general statutes, (3) "independent pharmacy" means any privately owned pharmacy that has not more than five stores located in this state,

(4) "pharmacist" has the same meaning as provided in section 20-571 of the general statutes, and (5) "pharmacy benefits manager" has the same meaning as provided in section 38a-479aaa of the general statutes.

(b) The working group convened pursuant to subsection (a) of this section shall consist of the following members:

(1) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, or their designees;

(2) The ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, or their designees;

(3) The Insurance Commissioner, or the commissioner's designee;

(4) The Commissioner of Consumer Protection, or the commissioner's designee;

(5) A pharmacist licensed under chapter 400j of the general statutes who is employed by any independent pharmacy;

(6) A pharmacist licensed under chapter 400j of the general statutes who is employed by any chain pharmacy;

(7) A representative of any organization representing pharmacy benefits managers;

(8) A representative of any health insurance company doing business in this state; and

(9) A representative of any pharmaceutical company doing business in this state.

(c) All initial appointments to the working group shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall serve as administrative staff of the working group.

(e) Not later than February 1, 2026, the working group shall submit a report on its findings and legislative recommendations to the joint standing committee of General Assembly having cognizance of matters relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date the working group submits such report or February 1, 2026, whichever is later.

Sec. 3. Subdivision (7) of section 38a-591a of the general statutes, as amended by section 32 of public act 24-19, is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(7) "Clinical peer" means a physician or other health care professional who:

(A) For a review other than one specified under subparagraph (B) or (C) of subdivision (38) of this section, (i) holds a nonrestricted license in a state of the United States**, [**in**]** and (ii) has (I) the same specialty as the treating physician or other health care professional who is managing the medical condition, procedure or treatment under review, or (II) substantial experience and expertise as a treating physician or other health care professional who typically manages the medical condition, procedure or treatment under review, provided only a physician may act as a clinical peer when the health care professional who is managing the medical condition, procedure or treatment under review is a physician; or

(B) For a review specified under subparagraph (B) or (C) of subdivision (38) of this section concerning:

(i) A child or adolescent substance use disorder or a child or adolescent mental disorder, holds (I) a national board certification in child and adolescent psychiatry, or (II) a doctoral level psychology

degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable; or

(ii) An adult substance use disorder or an adult mental disorder, holds (I) a national board certification in psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

Sec. 4. Section 38a-816 of the general statutes is amended by adding subdivisions (27) to (30), inclusive, as follows (*Effective October 1, 2025*):

(NEW) (27) (A) Where any health insurer or other entity responsible for providing payment to a health care provider pursuant to a contract between such health insurer or other entity and such health care provider maintains a health benefit plan incorporating certain health care providers as participating providers, failure of any such health insurer or other entity to make decisions in good faith based on the composition of the network of such participating providers, including, but not limited to, acceptance or denial of health care providers as participating providers. No such decision by such health insurer or other entity shall be based solely on any potential financial impact to such health insurer or other entity;

(B) Failure by any health insurer or other entity to provide written notice to any participating provider and any such designated representative of such participating provider, as applicable, of any decision by such health insurer or other entity that impacts such participating provider's status as a participating provider of such health insurer or other entity. Such notice shall provide an explanation of such decision by such health insurer or other entity; and

(C) Where any health insurer or other entity responsible for providing payment to a participating provider pursuant to a contract between such health insurer or other entity and such participating provider has reason to believe that such participating provider

misunderstands such participating provider's in-network or out-of-network status, failure to promptly resolve such misunderstanding.

(NEW) (28) (A) Where any health insurer or other entity responsible for providing payment to a participating provider pursuant to a contract between such health insurer or other entity and such participating provider has reason to believe that such participating provider has a designated representative or contracting agent, failure of such health insurer or other entity to provide to such designated representative or contracting agent of such participating provider any communication relating to such participating provider's status as a participating provider with such health insurer or other entity; and

(B) Attempting to circumvent, disrupt, undermine or otherwise interfere with the relationship between any participating provider and such participating provider's designated representative or contracting agent.

(NEW) (29) Where any health insurer or other entity responsible for providing payment to a participating provider pursuant to a contract between such health insurer or other entity and such participating provider has a written agreement or fee schedule in place with such participating provider or network of participating providers, failure to adhere to the provisions of such written agreement or fee schedule, or any attempt by such health insurer or other entity to circumvent or misrepresent such provisions of such written agreement or fee schedule.

(NEW) (30) Any violation of section 38a-472f, as amended by this act.

Sec. 5. Subparagraph (F) of subdivision (1) of subsection (e) of section 38a-472f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2025*):

(F) Timely notify a health care provider or facility, when such health carrier has (i) included such health care provider or facility as a participating provider for any of such health carrier's health benefit plans, **[**of such health care provider's or facility's network participation

status**]** (ii) denied such health care provider's or facility's request to be a participating provider for any of such health carrier's health benefit plans, or (iii) made any other change to such health care provider's or facility's status as a participating provider for any of such health carrier's health benefit plans. Any such notification by such health carrier pursuant to clause (ii) or (iii) of this subparagraph shall be in writing and provide an explanation of such denial or other such change to such health care provider's or facility's status as a participating provider. Any decision made by a health carrier pursuant to the provisions of this subparagraph shall be made in good faith and shall not be based solely on any potential financial impact to such health carrier;

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2026*	38a-479b(c)
Sec. 2	*from passage*	New section
Sec. 3	*January 1, 2026*	38a-591a(7)
Sec. 4	*October 1, 2025*	38a-816(27) to (30)
Sec. 5	*October 1, 2025*	38a-472f(e)(1)(F)

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill makes numerous changes that result in no fiscal impact to the state. The bill: (1) shortens health insurers' window to request return of payment due to billing error and makes various technical and procedural changes regarding health insurers; (2) requires a working group to study compensating pharmacists who provide health care services; (3) updates the "clinical peer" definition; and (4) establishes new practices that constitute unfair insurance practices with respect to health carrier conduct. No fiscal impact is expected because the Insurance Department does not anticipate a meaningful increase in workload and insurers are expected to comply.

OLR Bill Analysis

sHB 7039

AN ACT CONCERNING THE RETURN OF HEALTH CARE PROVIDER PAYMENTS, ESTABLISHING A WORKING GROUP TO STUDY PHARMACIST COMPENSATION FOR ADMINISTERING CERTAIN SERVICES, REVISING THE DEFINITION OF CLINICAL PEER AND CONCERNING THE CONNECTICUT UNFAIR INSURANCE PRACTICES ACT.

SUMMARY

This bill makes several changes to health insurance statutes. Principally, it does the following:

1. shortens, from 18 to 12 months, the time period during which contracting organizations (e.g., insurers, HMOs, and preferred provider networks) may cancel, deny, or demand the return of payment from a health care provider for an authorized covered service due to an administrative or eligibility error, and requires the organization to have an electronic appeal process in place;

2. for purposes of insurance adverse determination reviews, generally allows someone to serve as a clinical peer if he or she has substantial experience or expertise as a health care professional typically managing the condition under review; and

3. makes a health carrier's (a) violation of network adequacy requirements or (b) specified actions toward health care providers participating in the carrier's provider network (e.g., not acting in good faith when making network decisions and not adhering to a written agreement's provisions) punishable as unfair insurance practices.

Lastly, the bill requires the Insurance and Real Estate Committee's chairpersons, or their designees, to convene an 11-member working

group by July 1, 2025, to study compensating pharmacists who provide health care services (e.g., HIV and influenza testing, administering vaccines, and prescribing contraception). The group must report its findings and legislative recommendations to the committee by February 1, 2026.

EFFECTIVE DATE: October 1, 2025, except the provisions on the (1) return of provider payments and clinical peers are effective January 1, 2026, and (2) working group are effective upon passage.

§ 1 — THE RETURN OF HEALTH CARE PROVIDER PAYMENTS

The bill prohibits a contracting health organization, more than 12 months after receiving a clean (i.e. complete) claim (instead of 18 months as under current law), from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, unless the:

1. organization (a) has a documented basis to believe that the provider fraudulently submitted the claim, (b) already paid the provider for the claim, or (c) paid a claim that should have been or was paid by a federal or state program; or

2. provider (a) did not bill the claim appropriately based on documentation or evidence of what medical service was actually provided or (b) received payment from a different insurer, payor, or administrator through coordination of benefits or subrogation or due to coverage under an automobile insurance or workers' compensation policy.

By law, a contracting health organization must give a provider at least 30 days' advance notice of a payment cancellation, denial, or return demand. Current law requires the notice to be sent by mail, e-mail, or fax. The bill instead requires the organization to provide notice by certified mail, return receipt requested; e-mail to an e-mail address the provider designated; or fax.

Current law allows a provider to appeal a payment cancellation,

denial, or return demand within 30 days after receiving notice of it, in accordance with the organization's procedures. The bill specifies that an organization's procedures must include an electronic appeal process.

The bill also requires an organization to notify the provider of its appeal decision within 10 business days after receiving the appeal. If it fails to meet this deadline, the appeal is construed in favor of the provider.

§ 2 — WORKING GROUP ON COMPENSATING PHARMACISTS

The bill requires the Insurance and Real Estate Committee's chairpersons, or their designees, to convene an 11-member working group by July 1, 2025, to study and make legislative recommendations for compensating licensed pharmacists who provide health care services (e.g., HIV and influenza testing, administering vaccines, and prescribing contraception).

Required Membership

The bill requires the working group to consist of the following members:

1. the Insurance and Real Estate Committee chairpersons and ranking members, or their designees;

2. the insurance and consumer protection commissioners, or their designees;

3. two Connecticut-licensed pharmacists, one employed by an independent pharmacy (i.e. a privately owned pharmacy with up to five stores in the state) and one employed by a chain pharmacy (i.e. a community pharmacy that is publicly traded or has at least six stores in the state); and

4. one representative from each of the following: an organization representing pharmacy benefit managers, a health insurer doing business in the state, and a pharmaceutical company doing business in the state.

The bill requires all initial appointments to the working group to be made within 30 days after the bill's effective date. (Presumably the Insurance and Real Estate Committee chairpersons, or their designees, appoint the members, as they must convene the group.)

The bill also requires the Insurance and Real Estate Committee's administrative staff to be the working group's administrative staff.

The working group must report its findings and legislative recommendations to the Insurance and Real Estate Committee by February 1, 2026. It terminates when it submits its report or on February 1, 2026, whichever is later.

§ 3 — CLINICAL PEER QUALIFICATIONS

Under PA 24-19 (§ 32), beginning January 1, 2026, clinical peers doing adverse determination reviews generally must have a nonrestricted license (in any U.S. state) in the same specialty that typically manages the medical condition, procedure, or treatment under review. (Until that time, a clinical peer generally must have a nonrestricted license in the same or similar specialty.)

Beginning January 1, 2026, the bill instead generally requires these clinical peers to have (1) a nonrestricted license in the same specialty as the treating physician or other health care professional who is managing the condition, procedure, or treatment under review or (2) substantial experience or expertise as a treating physician or other health care professional who typically manages the condition, procedure, or treatment under review. However, only a physician may be a clinical peer when the health care professional managing the condition, procedure, or treatment under review is a physician.

By law, unchanged by the bill, for urgent care requests involving substance use or mental health disorders under certain circumstances, the clinical peer must be a (1) psychologist with relevant training and clinical experience or (2) psychiatrist.

§§ 4 & 5 — CUIPA VIOLATIONS FOR CERTAIN CARRIER CONDUCT

By law, carriers must timely notify a health care provider when the carrier includes the provider in its provider network. The bill also requires carriers to timely notify a provider in writing when the carrier has (1) denied the provider's request to join the carrier's network or (2) made any change to the provider's network status for any of the carrier's health benefit plans. These notifications must explain the denial or other change. The bill also requires a health carrier to make any decisions about a provider's network status in good faith and not solely based on any potential financial impacts to the carrier.

The bill makes the following carrier actions unfair insurance practices under the Connecticut Unfair Insurance Practices Act (CUIPA) (see BACKGROUND):

1. failure by a health carrier to make decisions in good faith based on its provider network's composition, including accepting or denying a provider as a participating provider;

2. failure to give written notice to a participating provider and his or her designated representative of any decision that impacts the provider's network status, including an explanation of the decision;

3. failure to promptly resolve any misunderstanding between the health carrier and a provider about the provider's network status;

4. failure to give a provider's designated representative or contracting agent communications about the provider's network status;

5. attempting to interfere with the relationship between a participating provider and his or her designated representative or contracting agent; and

6. failure by a health carrier to adhere to the provisions of a written agreement or fee schedule in place with a participating provider

or network of providers, or attempting to circumvent or misrepresent a written agreement or fee schedule.

Additionally, the bill makes a violation of the state's network adequacy and continuity of care statute (see BACKGROUND) a CUIPA violation.

BACKGROUND

CUIPA

CUIPA prohibits engaging in unfair or deceptive acts or practices in the business of insurance. It authorizes the insurance commissioner to conduct investigations and hearings, issue cease and desist orders, impose fines, revoke or suspend licenses, and order restitution for per se violations (i.e. violations specifically listed in statute). The law also allows the commissioner to ask the attorney general to seek injunctive relief in Superior Court if he believes someone is engaging in other unfair or deceptive acts not specifically defined in statute.

Fines may be up to (1) $5,000 per violation to a $50,000 maximum or (2) $25,000 per violation to a $250,000 maximum in any six-month period if the violation was knowingly committed. The law also imposes a fine of up to $50,000, in addition to or in lieu of a license suspension or revocation, for violating a cease and desist order (CGS §§ 38a-815 to -819).

Network Adequacy and Continuity of Care

Under the network adequacy statute, a health carrier must establish and maintain a network that includes a sufficient number and appropriate types of participating providers, including those that serve predominantly low-income, medically underserved people, to assure that all covered benefits will be accessible to all the carrier's covered persons without unreasonable travel or delay. Covered persons must have access to emergency services and, if urgent crisis center services are available, urgent crisis center services, 24 hours a day, seven days a week.

The law requires health carriers to (1) make a good faith effort to give

written notice to the patients of a participating provider who is leaving the carrier's network and (2) provide for the continuity of care for patients in active courses of treatment with the provider so as to allow them to continue their treatments and transition to different participating providers.

It also generally requires health carriers and hospitals involved in a contract dispute to continue to abide by the terms of their contract, including reimbursement terms, for 60 days after it expires or terminates (CGS § 38a-472f).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 10 Nay 3 (03/13/2025)