



Senate

General Assembly

File No. 419

January Session, 2025

Substitute Senate Bill No. 10

Senate, April 2, 2025

The Committee on Insurance and Real Estate reported through SEN. CABRERA of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION.

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

1 Section 1. (NEW) (*Effective October 1, 2025*) (a) As used in this section:

2 (1) "Health carrier" has the same meaning as provided in section 38a-
3 1080 of the general statutes; and

4 (2) "Mental health and substance use disorder benefits" has the same
5 meaning as provided in section 38a-477ee of the general statutes, as
6 amended by this act.

7 (b) (1) Not later than March 1, 2026, and annually thereafter, each
8 health carrier shall file a certification with the Insurance Commissioner
9 for the immediately preceding calendar year, certifying that such health
10 carrier completed a review of such health carrier's administrative
11 practices for compliance with the state and federal mental health and
12 substance use disorder benefit reporting requirements pursuant to
13 sections 38a-477ee, as amended by this act, 38a-488c, 38a-488d, 38a-514c,

14 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this act, and 38a-
15 544 of the general statutes, as amended by this act, and the provisions
16 of the federal Paul Wellstone and Pete Domenici Mental Health Parity
17 and Addiction Equity Act of 2008, P.L. 110-343, as amended from time
18 to time, and regulations adopted thereunder. Such certification shall be
19 signed by the chief executive officer and chief medical officer of such
20 health carrier.

21 (2) If such health carrier determines that such health carrier's
22 administrative practices for the immediately preceding calendar year
23 comply with the state and federal mental health and substance use
24 disorder benefit reporting requirements identified in subdivision (1) of
25 this subsection, such certification filed pursuant to subdivision (1) of this
26 subsection shall state such finding.

27 (3) If such health carrier determines that such health carrier's
28 administrative practices for the immediately preceding calendar year
29 fail to comply with the state and federal mental health and substance
30 use disorder benefit reporting requirements identified in subdivision (1)
31 of this subsection, such certification filed pursuant to subdivision (1) of
32 this subsection shall state such finding and identify (A) each
33 administrative practice of such health carrier not in compliance with
34 such state and federal mental health and substance use disorder benefit
35 reporting requirements, and (B) action that such health carrier will take
36 to bring such health carrier's administrative practices into compliance
37 with such state and federal mental health and substance use disorder
38 benefit reporting requirements.

39 Sec. 2. Subsection (c) of section 38a-477ee of the general statutes is
40 repealed and the following is substituted in lieu thereof (*Effective October*
41 *1, 2025*):

42 (c) [(1)] Not later than April 15, 2021, and annually thereafter, the
43 Insurance Commissioner shall submit each report that the
44 commissioner received pursuant to subsection (b) of this section for the
45 calendar year immediately preceding to:

46 [(A)] (1) The joint standing committee of the General Assembly
47 having cognizance of matters relating to insurance, in accordance with
48 section 11-4a; and

49 [(B)] (2) The Attorney General, Healthcare Advocate and
50 Commissioner of Health Strategy.

51 [(2) Notwithstanding subdivision (1) of this subsection, the
52 commissioner shall not submit the name or identity of any health carrier
53 or entity that has contracted with such health carrier, and such name or
54 identity shall be given confidential treatment and not be made public by
55 the commissioner.]

56 Sec. 3. (NEW) (*Effective from passage*) There is established an account
57 to be known as the "parity advancement account" which shall be a
58 separate, nonlapsing account within the General Fund. The account
59 shall contain any moneys required by law to be deposited in the account
60 and may receive donations from public or private sources. Moneys in
61 the account shall be expended by the Insurance Department, beginning
62 with the fiscal year ending June 30, 2026, for the purposes of enforcing
63 the state and federal mental health and substance use disorder benefit
64 reporting requirements identified in subdivision (1) of subsection (b) of
65 section 1 of this act, conducting consumer education and other
66 initiatives that support mental health parity implementation and
67 enforcement on behalf of consumers.

68 Sec. 4. (NEW) (*Effective October 1, 2025*) (a) (1) The commissioner, after
69 providing an opportunity for a hearing in accordance with chapter 54 of
70 the general statutes, may impose a civil penalty on any health carrier of
71 not more than one hundred dollars with respect to each participant or
72 beneficiary covered under a health insurance policy of such health
73 carrier, provided such penalty shall not exceed an aggregate amount of
74 one million dollars annually, for such health carrier's failure to comply
75 with the certification requirements pursuant to the provisions of section
76 1 of this act, or the state and federal mental health and substance use
77 disorder benefit reporting requirements identified in subdivision (1) of
78 subsection (b) of section 1 of this act.

79 (2) The commissioner may order the payment of such reasonable
80 expenses as may be necessary to compensate the commissioner in
81 conjunction with any proceedings under this section, which shall be
82 dedicated to the enforcement and implementation of the state and
83 federal mental health parity laws and regulations adopted thereunder.

84 (b) (1) If any health carrier fails to file any data, report, certification or
85 other information required by the provisions of section 38a-477ee of the
86 general statutes, as amended by this act, or section 1 of this act, the
87 commissioner shall impose a late fee on such health carrier of one
88 hundred dollars per day from the due date of such filing of data, report,
89 certification or information to the date such health carrier submits such
90 filing to the commissioner.

91 (2) For any health carrier that files any incomplete data, report,
92 certification or other information required by the provisions of section
93 38a-477ee of the general statutes, as amended by this act, and section 1
94 of this act, the commissioner shall provide notice to such health carrier
95 of such incomplete filing that includes (A) a description of such data,
96 report, certification or other information that is incomplete and any
97 additional data that is needed to consider such filing complete, and (B)
98 the date by which such health carrier is required to provide such data.
99 The commissioner shall impose a late fee on such health carrier of one
100 hundred dollars per day, commencing from the date identified by the
101 commissioner pursuant to subparagraph (B) of this subdivision.

102 (c) The commissioner may waive any civil penalty imposed pursuant
103 to subsection (a) of this section if the commissioner determines that the
104 violation was due to reasonable cause and was not due to wilful neglect,
105 or if such violation is corrected not more than thirty days after the date
106 that the health carrier filed a certification of noncompliance with the
107 commissioner pursuant to section 1 of this act.

108 (d) All civil penalties and late fees received by the commissioner
109 pursuant to this section shall be deposited in the General Fund and
110 credited to the parity advancement account established pursuant to
111 section 3 of this act.

112 Sec. 5. Subsections (a) and (b) of section 38a-591c of the general
113 statutes are repealed and the following is substituted in lieu thereof
114 (*Effective January 1, 2026*):

115 (a) (1) Each health carrier shall contract with (A) health care
116 professionals to administer such health carrier's utilization review
117 program, and (B) clinical peers to evaluate the clinical appropriateness
118 of an adverse determination.

119 (2) (A) Each utilization review program shall use documented clinical
120 review criteria that are based on sound clinical evidence and are
121 evaluated periodically by the health carrier's organizational mechanism
122 specified in subparagraph (F) of subdivision (2) of subsection (c) of
123 section 38a-591b to [assure] ensure such program's ongoing
124 effectiveness.

125 (B) Except as provided in subdivisions (3), (4) and (5) of this
126 subsection, a health carrier may develop its own clinical review criteria
127 or it may purchase or license clinical review criteria from qualified
128 vendors approved by the commissioner, provided such clinical review
129 criteria conform to the requirements of subparagraph (A) of this
130 subdivision.

131 (C) Each health carrier shall (i) post on its Internet web site (I) any
132 clinical review criteria it uses, and (II) links to any rule, guideline,
133 protocol or other similar criterion a health carrier may rely upon to make
134 an adverse determination as described in subparagraph (F) of
135 subdivision (1) of subsection (e) of section 38a-591d, and (ii) make its
136 clinical review criteria available upon request to authorized government
137 agencies.

138 (D) For each utilization review, there shall be a rebuttable
139 presumption that each health care service under review is medically
140 necessary if such health care service was ordered by a health care
141 professional acting within such health care professional's scope of
142 practice. Any utilization review company performing such review of a
143 health care service shall have the burden of proving that such health

144 care service is not medically necessary.

145 (3) For any utilization review for the treatment of a substance use
146 disorder, as described in section 17a-458, the clinical review criteria used
147 shall be: (A) The most recent edition of the American Society of
148 Addiction Medicine Treatment Criteria for Addictive, Substance-
149 Related, and Co-Occurring Conditions; or (B) clinical review criteria that
150 the health carrier demonstrates to the Insurance Department is
151 consistent with the most recent edition of the American Society of
152 Addiction Medicine Treatment Criteria for Addictive, Substance-
153 Related, and Co-Occurring Conditions, except that nothing in this
154 subdivision shall prohibit a health carrier from developing its own
155 clinical review criteria or purchasing or licensing additional clinical
156 review criteria from qualified vendors approved by the commissioner,
157 to address advancements in technology or types of care for the
158 treatment of a substance use disorder, that are not covered in the most
159 recent edition of the American Society of Addiction Medicine Treatment
160 Criteria for Addictive, Substance-Related, and Co-Occurring
161 Conditions. Any such clinical review criteria developed by a health
162 carrier or purchased or licensed from a qualified vendor shall conform
163 to the requirements of subparagraph (A) of subdivision (2) of this
164 subsection.

165 (4) For any utilization review for the treatment of a child or
166 adolescent mental disorder, the clinical review criteria used shall be: (A)
167 The most recent guidelines of the American Academy of Child and
168 Adolescent Psychiatry's Child and Adolescent Service Intensity
169 Instrument; or (B) clinical review criteria that the health carrier
170 demonstrates to the Insurance Department is consistent with the most
171 recent guidelines of the American Academy of Child and Adolescent
172 Psychiatry's Child and Adolescent Service Intensity Instrument, except
173 that nothing in this subdivision shall prohibit a health carrier from
174 developing its own clinical review criteria or purchasing or licensing
175 additional clinical review criteria from qualified vendors approved by
176 the commissioner, to address advancements in technology or types of
177 care for the treatment of a child or adolescent mental disorder, that are

178 not covered in the most recent guidelines of the American Academy of
179 Child and Adolescent Psychiatry's Child and Adolescent Service
180 Intensity Instrument. Any such clinical review criteria developed by a
181 health carrier or purchased or licensed from a qualified vendor shall
182 conform to the requirements of subparagraph (A) of subdivision (2) of
183 this subsection.

184 (5) For any utilization review for the treatment of an adult mental
185 disorder, the clinical review criteria used shall be: (A) The most recent
186 guidelines of the American Psychiatric Association or the most recent
187 Standards and Guidelines of the Association for Ambulatory Behavioral
188 Healthcare; or (B) clinical review criteria that the health carrier
189 demonstrates to the Insurance Department is consistent with the most
190 recent guidelines of the American Psychiatric Association or the most
191 recent Standards and Guidelines of the Association for Ambulatory
192 Behavioral Healthcare, except that nothing in this subdivision shall
193 prohibit a health carrier from developing its own clinical review criteria
194 or purchasing or licensing additional clinical review criteria from
195 qualified vendors approved by the commissioner, to address
196 advancements in technology or types of care for the treatment of an
197 adult mental disorder, that are not covered in the most recent guidelines
198 of the American Psychiatric Association or the most recent Standards
199 and Guidelines of the Association for Ambulatory Behavioral
200 Healthcare. Any such clinical review criteria developed by a health
201 carrier or purchased or licensed from a qualified vendor shall conform
202 to the requirements of subparagraph (A) of subdivision (2) of this
203 subsection.

204 (b) Each health carrier shall:

205 (1) Have procedures in place to ensure that (A) the health care
206 professionals administering such health carrier's utilization review
207 program are applying the clinical review criteria consistently in
208 utilization review determinations, and (B) the appropriate or required
209 individual or individuals are being designated to conduct utilization
210 reviews;

211 (2) Have data systems sufficient to support utilization review
212 program activities and to generate management reports to enable the
213 health carrier to monitor and manage health care services effectively;

214 (3) Provide covered persons and participating providers with access
215 to its utilization review staff through a toll-free telephone number or
216 any other free calling option or by electronic means;

217 (4) Coordinate the utilization review program with other medical
218 management activity conducted by the health carrier, such as quality
219 assurance, credentialing, contracting with health care professionals,
220 data reporting, grievance procedures, processes for assessing member
221 satisfaction and risk management; [and]

222 (5) Routinely assess the effectiveness and efficiency of its utilization
223 review program; and

224 (6) Not use any system that employs artificial intelligence, as defined
225 in section 51-10e, or any other algorithm in lieu of a review by a clinical
226 peer to evaluate the clinical appropriateness of an adverse
227 determination pursuant to a contract between such clinical peer and
228 such health carrier.

229 Sec. 6. Subsection (c) of section 38a-591e of the general statutes is
230 repealed and the following is substituted in lieu thereof (*Effective January*
231 *1, 2026*):

232 (c) (1) (A) When conducting a review of an adverse determination
233 under this section, the health carrier shall ensure that such review is
234 conducted in a manner to ensure the independence and impartiality of
235 the clinical peer or peers involved in making the review decision.

236 (B) If the adverse determination involves utilization review, the
237 health carrier shall designate an appropriate clinical peer or peers to
238 review such adverse determination. Such clinical peer or peers shall not
239 have been involved in the initial adverse determination.

240 (C) (i) To effectuate the rebuttable presumption pursuant to

241 subparagraph (D) of subdivision (2) of subsection (a) of section 38a-591c,
242 as amended by this act, the health carrier may rebut such presumption
243 by reasonably substantiating to the clinical peer or peers conducting the
244 review pursuant to the provisions of this section that such health care
245 service is not medically necessary.

246 [(C)] (ii) The clinical peer or peers conducting a review under this
247 section shall take into consideration all comments, documents, records
248 and other information relevant to the covered person's benefit request
249 that is the subject of the adverse determination under review, that are
250 submitted by the covered person or the covered person's authorized
251 representative, regardless of whether such information was submitted
252 or considered in making the initial adverse determination.

253 (D) Prior to issuing a decision, the health carrier shall provide free of
254 charge, by facsimile, electronic means or any other expeditious method
255 available, to the covered person or the covered person's authorized
256 representative, as applicable, any new or additional documents,
257 communications, information and evidence relied upon and any new or
258 additional scientific or clinical rationale used by the health carrier in
259 connection with the grievance. Such documents, communications,
260 information, evidence and rationale shall be provided sufficiently in
261 advance of the date the health carrier is required to issue a decision to
262 permit the covered person or the covered person's authorized
263 representative, as applicable, a reasonable opportunity to respond prior
264 to such date.

265 (2) If the review under subdivision (1) of this subsection is an
266 expedited review, all necessary information, including the health
267 carrier's decision, shall be transmitted between the health carrier and the
268 covered person or the covered person's authorized representative, as
269 applicable, by telephone, facsimile, electronic means or any other
270 expeditious method available.

271 (3) If the review under subdivision (1) of this subsection is an
272 expedited review of a grievance involving an adverse determination of
273 a concurrent review request, pursuant to 45 CFR 147.136, as amended

274 from time to time, the treatment shall be continued without liability to
275 the covered person until the covered person has been notified of the
276 review decision.

277 Sec. 7. Section 38a-510 of the general statutes is repealed and the
278 following is substituted in lieu thereof (*Effective January 1, 2026*):

279 (a) No insurance company, hospital service corporation, medical
280 service corporation, health care center or other entity delivering, issuing
281 for delivery, renewing, amending or continuing an individual health
282 insurance policy or contract that provides coverage for prescription
283 drugs may:

284 (1) Require any person covered under such policy or contract to
285 obtain prescription drugs from a mail order pharmacy as a condition of
286 obtaining benefits for such drugs; or

287 (2) Require, if such insurance company, hospital service corporation,
288 medical service corporation, health care center or other entity uses step
289 therapy for such drugs, the use of step therapy (A) for any prescribed
290 drug for longer than [thirty] twenty days, (B) for a prescribed drug for
291 [cancer treatment for an insured who has been diagnosed with stage IV
292 metastatic cancer] the treatment of a disabling or life-threatening
293 chronic disease or condition, provided such prescribed drug is in
294 compliance with approved federal Food and Drug Administration
295 indications, [or] (C) for the period commencing January 1, 2024, and
296 ending January 1, 2027, inclusive, for the treatment of schizophrenia,
297 major depressive disorder or bipolar disorder, as defined in the most
298 recent edition of the American Psychiatric Association's "Diagnostic and
299 Statistical Manual of Mental Disorders", or (D) for a prescribed drug for
300 the treatment of a mental or behavioral health condition, provided such
301 prescribed drug is in compliance with approved federal Food and Drug
302 Administration indications.

303 (3) At the expiration of the time period specified in subparagraph (A)
304 of subdivision (2) of this subsection or for a prescribed drug described
305 in [subparagraph (B) or (C)] subparagraphs (B) to (D), inclusive, of

306 subdivision (2) of this subsection, an insured's treating health care
307 provider may deem such step therapy drug regimen clinically
308 ineffective for the insured, at which time the insurance company,
309 hospital service corporation, medical service corporation, health care
310 center or other entity shall authorize dispensation of and coverage for
311 the drug prescribed by the insured's treating health care provider,
312 provided such drug is a covered drug under such policy or contract. If
313 such provider does not deem such step therapy drug regimen clinically
314 ineffective or has not requested an override pursuant to subdivision (1)
315 of subsection (b) of this section, such drug regimen may be continued.
316 For purposes of this section, "step therapy" means a protocol or program
317 that establishes the specific sequence in which prescription drugs for a
318 specified medical condition are to be prescribed.

319 (b) (1) Notwithstanding the [sixty-day] twenty-day period set forth
320 in subparagraph (A) of subdivision (2) of subsection (a) of this section,
321 each insurance company, hospital service corporation, medical service
322 corporation, health care center or other entity that uses step therapy for
323 such prescription drugs shall establish and disclose to its health care
324 providers a process by which an insured's treating health care provider
325 may request at any time an override of the use of any step therapy drug
326 regimen. Any such override process shall be convenient to use by health
327 care providers and an override request shall be expeditiously granted
328 when an insured's treating health care provider demonstrates that the
329 drug regimen required under step therapy (A) has been ineffective in
330 the past for treatment of the insured's medical condition, (B) is expected
331 to be ineffective based on the known relevant physical or mental
332 characteristics of the insured and the known characteristics of the drug
333 regimen, (C) will cause or will likely cause an adverse reaction by or
334 physical harm to the insured, or (D) is not in the best interest of the
335 insured, based on medical necessity.

336 (2) Upon the granting of an override request, the insurance company,
337 hospital service corporation, medical service corporation, health care
338 center or other entity shall authorize dispensation of and coverage for
339 the drug prescribed by the insured's treating health care provider,

340 provided such drug is a covered drug under such policy or contract.

341 (c) Nothing in this section shall (1) preclude an insured or an
342 insured's treating health care provider from requesting a review under
343 sections 38a-591c to 38a-591g, inclusive, as amended by this act, or (2)
344 affect the provisions of section 38a-492i.

345 Sec. 8. Section 38a-544 of the general statutes is repealed and the
346 following is substituted in lieu thereof (*Effective January 1, 2026*):

347 (a) No insurance company, hospital service corporation, medical
348 service corporation, health care center or other entity delivering, issuing
349 for delivery, renewing, amending or continuing a group health
350 insurance policy or contract that provides coverage for prescription
351 drugs may:

352 (1) Require any person covered under such policy or contract to
353 obtain prescription drugs from a mail order pharmacy as a condition of
354 obtaining benefits for such drugs; or

355 (2) Require, if such insurance company, hospital service corporation,
356 medical service corporation, health care center or other entity uses step
357 therapy for such drugs, the use of step therapy (A) for any prescribed
358 drug for longer than [thirty] twenty days, (B) for a prescribed drug for
359 [cancer treatment for an insured who has been diagnosed with stage IV
360 metastatic cancer] the treatment of a disabling or life-threatening
361 chronic disease or condition, provided such prescribed drug is in
362 compliance with approved federal Food and Drug Administration
363 indications, [or] (C) for the period commencing January 1, 2024, and
364 ending January 1, 2027, inclusive, for the treatment of schizophrenia,
365 major depressive disorder or bipolar disorder, as defined in the most
366 recent edition of the American Psychiatric Association's "Diagnostic and
367 Statistical Manual of Mental Disorders", or (D) for a prescribed drug for
368 the treatment of a mental or behavioral health condition, provided such
369 prescribed drug is in compliance with approved federal Food and Drug
370 Administration indications.

371 (3) At the expiration of the time period specified in subparagraph (A)
372 of subdivision (2) of this subsection or for a prescribed drug described
373 in [subparagraph (B) or (C)] subparagraphs (B) to (D), inclusive, of
374 subdivision (2) of this subsection, an insured's treating health care
375 provider may deem such step therapy drug regimen clinically
376 ineffective for the insured, at which time the insurance company,
377 hospital service corporation, medical service corporation, health care
378 center or other entity shall authorize dispensation of and coverage for
379 the drug prescribed by the insured's treating health care provider,
380 provided such drug is a covered drug under such policy or contract. If
381 such provider does not deem such step therapy drug regimen clinically
382 ineffective or has not requested an override pursuant to subdivision (1)
383 of subsection (b) of this section, such drug regimen may be continued.
384 For purposes of this section, "step therapy" means a protocol or program
385 that establishes the specific sequence in which prescription drugs for a
386 specified medical condition are to be prescribed.

387 (b) (1) Notwithstanding the [sixty-day] twenty-day period set forth
388 in subparagraph (A) of subdivision (2) of subsection (a) of this section,
389 each insurance company, hospital service corporation, medical service
390 corporation, health care center or other entity that uses step therapy for
391 such prescription drugs shall establish and disclose to its health care
392 providers a process by which an insured's treating health care provider
393 may request at any time an override of the use of any step therapy drug
394 regimen. Any such override process shall be convenient to use by health
395 care providers and an override request shall be expeditiously granted
396 when an insured's treating health care provider demonstrates that the
397 drug regimen required under step therapy (A) has been ineffective in
398 the past for treatment of the insured's medical condition, (B) is expected
399 to be ineffective based on the known relevant physical or mental
400 characteristics of the insured and the known characteristics of the drug
401 regimen, (C) will cause or will likely cause an adverse reaction by or
402 physical harm to the insured, or (D) is not in the best interest of the
403 insured, based on medical necessity.

404 (2) Upon the granting of an override request, the insurance company,

405 hospital service corporation, medical service corporation, health care
406 center or other entity shall authorize dispensation of and coverage for
407 the drug prescribed by the insured's treating health care provider,
408 provided such drug is a covered drug under such policy or contract.

409 (c) Nothing in this section shall (1) preclude an insured or an
410 insured's treating health care provider from requesting a review under
411 sections 38a-591c to 38a-591g, inclusive, as amended by this act, or (2)
412 affect the provisions of section 38a-518i.

413 Sec. 9. (NEW) (*Effective July 1, 2026*) (a) Each insurer, health care
414 center, hospital service corporation, medical service corporation,
415 preferred provider network or other entity that enters into, renews or
416 amends a contract with a health care provider on or after July 1, 2026, to
417 provide covered benefits to insureds or enrollees in this state shall
418 include in such contract:

419 (1) A provision requiring such insurer, health care center, hospital
420 service corporation, medical service corporation, preferred provider
421 network or other entity to:

422 (A) Reimburse the contracting health care provider for a covered
423 outpatient benefit that uses a current procedural terminology
424 evaluation and management (CPT E/M) code, current procedural
425 terminology assessment and management (CPT A/M) code or drug
426 infusion code in an amount that does not vary based on the facility
427 where the contracting health care provider provides such benefit; and

428 (B) Use equal reimbursement rates for all contracting health care
429 providers in the same geographic region, as determined by the
430 Insurance Commissioner, in accordance with the provisions of chapter
431 54 of the general statutes, and regardless of the employer or affiliation
432 of any contracting health care provider, for each covered outpatient
433 benefit described in subparagraph (A) of this subdivision if the
434 reimbursement for such covered outpatient benefit is made on a fee-for-
435 benefit basis or on the basis of bundled benefits per diagnosis, condition,
436 procedure or another standardized bundle of health care benefits; and

437 (2) A conspicuous statement that such contract complies with the
438 provisions of subdivision (1) of this subsection.

439 (b) The Insurance Commissioner shall adopt regulations, in
440 accordance with the provisions of chapter 54 of the general statutes, to
441 implement the provisions of this section, including, but not limited to,
442 the establishment of geographic regions pursuant to the provisions of
443 subparagraph (B) of subdivision (1) of subsection (a) of this section.

444 Sec. 10. Subsections (a) to (c), inclusive, of section 38a-481 of the
445 general statutes are repealed and the following is substituted in lieu
446 thereof (*Effective January 1, 2026*):

447 (a) No individual health insurance policy shall be delivered or issued
448 for delivery to any person in this state, nor shall any application, rider
449 or endorsement be used in connection with such policy, until a copy of
450 the form thereof and of the classification of risks and the premium rates
451 have been filed with the commissioner. Rate filings shall include the
452 information and data required under section 38a-479qqq if the policy is
453 subject to said section, and an actuarial memorandum that includes, but
454 is not limited to, pricing assumptions and claims experience, the
455 requirements established in section 15 of this act, and premium rates
456 and loss ratios from the inception of the policy. Each premium rate filed
457 on or after January 1, 2021, shall, if the insurer intends to account for
458 rebates, as defined in section 38a-479ooo in the manner specified in
459 section 38a-479rrr, account for such rebates in such manner, if the policy
460 is subject to section 38a-479rrr. The commissioner may adopt
461 regulations, in accordance with the provisions of chapter 54, to establish
462 a procedure for reviewing such policies. The commissioner shall
463 disapprove the use of such form at any time if it does not comply with
464 the requirements of law, or if it contains a provision or provisions that
465 are unfair or deceptive or that encourage misrepresentation of the
466 policy. The commissioner shall notify, in writing, the insurer that has
467 filed any such form of the commissioner's disapproval, specifying the
468 reasons for disapproval, and ordering that no such insurer shall deliver
469 or issue for delivery to any person in this state a policy on or containing

470 such form. The provisions of section 38a-19 shall apply to such orders.
471 As used in this subsection, "loss ratio" means the ratio of incurred claims
472 to earned premiums by the number of years of policy duration for all
473 combined durations.

474 (b) (1) No rate filed under the provisions of subsection (a) of this
475 section shall be effective until it has been approved by the commissioner
476 in accordance with regulations adopted pursuant to this subsection. The
477 commissioner shall adopt regulations, in accordance with the
478 provisions of chapter 54, to prescribe standards to ensure that such rates
479 shall not be excessive, inadequate, [or] unfairly discriminatory [. The
480 commissioner may disapprove such rate if it fails to comply with such
481 standards, except that no rate filed under the provisions of subsection
482 (a) of this section for any Medicare supplement policy shall be effective
483 unless approved in accordance with section 38a-474] or unaffordable
484 pursuant to the provisions of section 15 of this act.

485 (2) Any rate filed in accordance with the provisions of subsection (a)
486 of this section for health insurance that provides coverage of the type
487 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall
488 be approved in accordance with the provisions of section 15 of this act.

489 (c) (1) No rate filed in accordance with the provisions of subsection
490 (a) of this section for any Medicare supplement policy shall be effective
491 unless approved in accordance with the provisions of section 38a-474.

492 [(c)] (2) No insurance company, fraternal benefit society, hospital
493 service corporation, medical service corporation, health care center or
494 other entity that delivers or issues for delivery in this state any Medicare
495 supplement policies or certificates shall incorporate in its rates or
496 determinations to grant coverage for Medicare supplement insurance
497 policies or certificates any factors or values based on the age, gender,
498 previous claims history or the medical condition of any person covered
499 by such policy or certificate.

500 Sec. 11. Section 38a-513 of the general statutes is repealed and the
501 following is substituted in lieu thereof (*Effective January 1, 2026*):

502 (a) [(1)] No group health insurance policy, as defined by the
503 commissioner, or certificate shall be delivered or issued for delivery in
504 this state unless a copy of the form for such policy or certificate has been
505 submitted to and approved by the commissioner under the regulations
506 adopted pursuant to this section. The commissioner shall adopt
507 regulations, in accordance with the provisions of chapter 54, concerning
508 the provisions, submission and approval of such policies and certificates
509 and establishing a procedure for reviewing such policies and
510 certificates. The commissioner shall disapprove the use of such form at
511 any time if it does not comply with the requirements of law, or if it
512 contains a provision or provisions that are unfair or deceptive or that
513 encourage misrepresentation of the policy. The commissioner shall
514 notify, in writing, the insurer that has filed any such form of the
515 commissioner's disapproval, specifying the reasons for disapproval,
516 and ordering that no such insurer shall deliver or issue for delivery to
517 any person in this state a policy on or containing such form. The
518 provisions of section 38a-19 shall apply to such order.

519 (b) (1) No rate filed in accordance with the provisions of subsection
520 (a) of this section shall be effective until such rate has been approved by
521 the commissioner in accordance with regulations adopted pursuant to
522 this subsection or as provided under subdivision (2) of this subsection.
523 The commissioner shall adopt regulations, in accordance with the
524 provisions of chapter 54, to prescribe standards to ensure that such rates
525 shall not be excessive, inadequate, unfairly discriminatory or
526 unaffordable pursuant to the provisions of section 15 of this act.

527 (2) Any rate filed in accordance with the provisions of subsection (a)
528 of this section for a group health insurance policy that provides
529 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)
530 of section 38a-469 shall be approved in accordance with the provisions
531 of section 15 of this act.

532 [(2)] (c) No group health insurance policy or certificate for a small
533 employer, as defined in section 38a-564, shall be delivered or issued for
534 delivery in this state unless the premium rates have been submitted to

535 and approved by the commissioner in accordance with the provisions
536 of section 15 of this act. Premium rate filings shall include the
537 information and data required under section 38a-479qqq if the policy is
538 subject to said section, and an actuarial memorandum that includes, but
539 is not limited to, pricing assumptions and claims experience, the
540 requirements set forth in section 15 of this act, and premium rates and
541 loss ratios from the inception of the policy. Each premium rate filed on
542 or after January 1, 2021, shall, if the insurer intends to account for
543 rebates, as defined in section 38a-479ooo in the manner specified in
544 section 38a-479rrr, account for such rebates in such manner, if the policy
545 is subject to section 38a-479rrr. As used in this subdivision, "loss ratio"
546 means the ratio of incurred claims to earned premiums by the number
547 of years of policy duration for all combined durations.

548 [(b)] (d) No insurance company, fraternal benefit society, hospital
549 service corporation, medical service corporation, health care center or
550 other entity that delivers or issues for delivery in this state any Medicare
551 supplement policies or certificates shall incorporate in its rates or
552 determinations to grant coverage for Medicare supplement insurance
553 policies or certificates any factors or values based on the age, gender,
554 previous claims history or the medical condition of any person covered
555 by such policy or certificate.

556 [(c)] (e) Nothing in this chapter shall preclude the issuance of a group
557 health insurance policy that includes an optional life insurance rider,
558 provided the optional life insurance rider shall be filed with and
559 approved by the Insurance Commissioner pursuant to section 38a-430.
560 Any company offering such policies for sale in this state shall be licensed
561 to sell life insurance in this state pursuant to the provisions of section
562 38a-41.

563 [(d)] (f) Not later than January 1, 2009, the commissioner shall adopt
564 regulations, in accordance with chapter 54, to establish minimum
565 standards for benefits in group specified disease policies, certificates,
566 riders, endorsements and benefits.

567 Sec. 12. Subdivision (1) of subsection (a) of section 38a-183 of the

568 general statutes is repealed and the following is substituted in lieu
569 thereof (*Effective January 1, 2026*):

570 (a) (1) A health care center governed by sections 38a-175 to 38a-194,
571 inclusive, shall not enter into any agreement with subscribers unless and
572 until [it] such health care center has filed with the commissioner a full
573 schedule of the amounts to be paid by the subscribers and has obtained
574 the commissioner's approval [thereof] in accordance with the provisions
575 of section 15 of this act. Such filing shall include the information and
576 data required under section 38a-479qqq if the contract or policy is
577 subject to said section, and an actuarial memorandum that includes, but
578 is not limited to, pricing assumptions and claims experience, and
579 premium rates and loss ratios from the inception of the contract or
580 policy. The commissioner [may refuse such approval if the
581 commissioner finds such amounts to] shall adopt regulations, in
582 accordance with the provisions of chapter 54, to prescribe standards to
583 ensure that such amounts shall not be excessive, inadequate, [or]
584 discriminatory or unaffordable pursuant to the provisions of section 15
585 of this act. As used in this subsection, "loss ratio" means the ratio of
586 incurred claims to earned premiums by the number of years of policy
587 duration for all combined durations.

588 Sec. 13. Subsection (a) of section 38a-208 of the general statutes is
589 repealed and the following is substituted in lieu thereof (*Effective January*
590 *1, 2026*):

591 (a) No such corporation shall enter into any contract with subscribers
592 unless and until it has filed with the Insurance Commissioner a full
593 schedule of the rates to be paid by the subscribers and has obtained said
594 commissioner's approval [thereof] in accordance with the provisions of
595 section 15 of this act. Such filing shall include an actuarial memorandum
596 that includes, but is not limited to, pricing assumptions and claims
597 experience, and premium rates and loss ratios from the inception of the
598 contract. The commissioner [may refuse such approval if the
599 commissioner finds such rates to] shall adopt regulations, in accordance
600 with the provisions of chapter 54, to prescribe standards to ensure that

601 such amounts shall not be excessive, inadequate, [or] discriminatory or
602 unaffordable pursuant to the provisions of section 15 of this act. As used
603 in this subsection, "loss ratio" means the ratio of incurred claims to
604 earned premiums by the number of years of policy duration for all
605 combined durations.

606 Sec. 14. Subsection (a) of section 38a-218 of the general statutes is
607 repealed and the following is substituted in lieu thereof (*Effective January*
608 *1, 2026*):

609 (a) No such medical service corporation shall enter into any contract
610 with subscribers unless and until it has filed with the Insurance
611 Commissioner a full schedule of the rates to be paid by the subscriber
612 and has obtained said commissioner's approval [thereof] in accordance
613 with the provisions of section 15 of this act. Such filing shall include an
614 actuarial memorandum that includes, but is not limited to, pricing
615 assumptions and claims experience, and premium rates and loss ratios
616 from the inception of the contract. The commissioner [may refuse such
617 approval if the commissioner finds such rates are] shall adopt
618 regulations, in accordance with the provisions of chapter 54, to prescribe
619 standards to ensure that such amounts shall not be excessive,
620 inadequate, [or] discriminatory or unaffordable pursuant to the
621 provisions of section 15 of this act. As used in this subsection, "loss ratio"
622 means the ratio of incurred claims to earned premiums by the number
623 of years of policy duration for all combined durations.

624 Sec. 15. (NEW) (*Effective January 1, 2026*) (a) (1) With respect to a
625 health insurance policy, agreement or contract that provides coverage
626 of the type specified in subdivisions (1), (2), (4), (11) and (12) of section
627 38a-469 of the general statutes, any (A) rate filed for such policy
628 pursuant to section 38a-481 of the general statutes, as amended by this
629 act, (B) rate filed for such policy pursuant to section 38a-513 of the
630 general statutes, as amended by this act, (C) schedule of amounts filed
631 for such agreement pursuant to section 38a-183 of the general statutes,
632 as amended by this act, (D) schedule of rates filed for such contract
633 pursuant to section 38a-208 of the general statutes, as amended by this

634 act, or (E) schedule of rates filed for such contract pursuant to section
635 38a-218 of the general statutes, as amended by this act, on or after
636 January 1, 2026, shall be filed not later than one hundred twenty
637 calendar days prior to the proposed effective date of such rates or
638 amounts.

639 (2) Each filer making a rate or amount filing pursuant to this
640 subsection shall, on the date such filer submits such rate or amount
641 filing to the Insurance Commissioner, include with such filer's rate or
642 amount filing an actuarial memorandum, certified by a qualified
643 actuary, that to the best of such actuary's knowledge, (A) such rate or
644 amount filing is in compliance with the laws of this state and federal
645 law, as applicable, and (B) the rate or amount filing is not excessive, as
646 described in subdivision (1) of subsection (c) of this section. For the
647 purposes of this subparagraph, "qualified actuary" means a member in
648 good standing of the American Academy of Actuaries who is qualified
649 in accordance with the standards of the American Academy of
650 Actuaries.

651 (3) (A) Notwithstanding the provisions of section 38a-69a of the
652 general statutes, the Insurance Department shall post on the
653 department's Internet web site all documents, materials and other
654 information provided to or requested by the department in relation to
655 any such rate or amount filing made pursuant to this subsection,
656 including, but not limited to, financial reports, financial statements,
657 actuarial reports and actuarial memoranda. Such rate or amount filing
658 and such documents, materials and other information shall be posted
659 on such web site not later than three business days after the department
660 receives such filing, and such posting shall be updated to include any
661 correspondence between the department and such filer.

662 (B) The department shall provide for a written public comment
663 period of not less than thirty calendar days following the posting of such
664 filing. The department shall include in such posting the date such public
665 comment period closes and instructions for the public to submit
666 comments to the department.

667 (b) (1) The commissioner shall hold a public hearing for each rate or
668 amount filed under the provisions of subdivision (1) of subsection (a) of
669 this section. Not later than five business days after the posting of such
670 rate or amount filing on the department's Internet web site in
671 accordance with the provisions of subparagraph (A) of subdivision (3)
672 of subsection (a) of this section, the commissioner shall set a public
673 hearing date for such rate or amount filing and shall post the date, place
674 and time of such public hearing in a conspicuous place on the
675 department's Internet web site.

676 (2) Such public hearing shall be (A) held after the end of the public
677 comment period specified in subparagraph (B) of subdivision (3) of
678 subsection (a) of this section, but not later than prior to the proposed
679 effective date of such rate or amount, at a place and time that is
680 convenient to the public, and (B) conducted in accordance with the
681 provisions of chapter 54 of the general statutes, this section and section
682 16 of this act.

683 (3) Upon setting the date, place and time of the public hearing for
684 such rate or amount filing, the commissioner shall immediately notify
685 the filer of such rate or amount filing of the date, place and time of the
686 public hearing.

687 (c) The commissioner shall not approve a rate or amount filing
688 submitted in accordance with the provisions of this section if such rate
689 or amount filing is excessive, inadequate, unfairly discriminatory or
690 unaffordable. The commissioner shall conduct an actuarial review to
691 determine if the methodology and assumptions used to develop such
692 rate or amount filing are actuarially sound and in compliance with the
693 Actuarial Standards of Practice issued by the Actuarial Standards Board.

694 (1) Any rate or amount shall be considered excessive if it is
695 unreasonably high for the insurance provided in relation to the
696 underlying risks and costs after due consideration of: (A) The
697 experience of such filer; (B) such filer's past and projected costs,
698 including amounts to be paid for commissions; (C) any transfers of
699 funds to the holding or parent company, subsidiary or affiliate of such

700 filer; (D) such filer's rate of return on assets or profitability, as compared
701 to similar filers; (E) a reasonable margin for profit and contingencies; (F)
702 any public comments received on such filing in accordance with the
703 provisions of subparagraph (B) of subdivision (3) of subsection (a) of
704 this section; and (G) other factors the commissioner deems relevant.

705 (2) Any rate or amount shall be considered inadequate if such rate or
706 amount is unreasonably low for the insurance provided in relation to
707 the underlying risks and costs and continued use of such rate or amount
708 would endanger solvency of such filer.

709 (3) Any rate or amount shall be considered unfairly discriminatory if
710 the premium charged for any classification is not reasonably related to
711 the underlying risks and costs, such that different premiums result for
712 insureds with similar risks and costs.

713 (4) Any rate or amount shall be considered unaffordable if the
714 commissioner determines such rate or amount is inconsistent with the
715 inflation-adjusted Connecticut Health Affordability Index
716 commissioned by the Office of Health Strategy and the Office of the
717 State Comptroller, or another metric jointly designated by the
718 commissioner and the Commissioner of Health Strategy.

719 (d) Not later than thirty days after such public hearing held in
720 accordance with the provisions of subsection (b) of this section, the
721 commissioner shall issue a written decision approving, disapproving or
722 modifying such rate or amount filing. Such decision shall specify all
723 factors used to reach such decision and shall be posted on the
724 department's Internet web site not later than two business days after the
725 commissioner issues such decision.

726 Sec. 16. (NEW) (*Effective January 1, 2026*) (a) Notwithstanding sections
727 4-176 and 4-177a of the general statutes, the Healthcare Advocate or the
728 Attorney General, or both, may be parties to any public hearing held in
729 accordance with the provisions of section 15 of this act.

730 (b) Subject to the provisions of section 4-181 of the general statutes,

731 (1) the Healthcare Advocate or the Attorney General, or both, shall have
732 access to the records of the Insurance Department regarding any rate or
733 amount filing made in accordance with the provisions of section 15 of
734 this act, and (2) attorneys, actuaries, accountants and other experts who
735 are part of the Insurance Commissioner's staff and who review or assist
736 in the determination of such filing pursuant to the provisions of section
737 15 of this act shall cooperate with the Healthcare Advocate or Attorney
738 General, or both, to carry out the provisions of this section.

739 (c) The Healthcare Advocate or the Attorney General, or both, may
740 (1) summon and examine under oath such witnesses as the Healthcare
741 Advocate or the Attorney General deems necessary for the review of a
742 rate or amount filing made in accordance with the provisions of section
743 15 of this act, and (2) require the filer or any holding or parent company
744 or subsidiary of such filer to produce books, vouchers, memoranda,
745 papers, letters, contracts and other documents, regardless of the format
746 in which such materials are stored. Any such books, vouchers,
747 memoranda, papers, letters, contracts or other documents shall be
748 limited to such information or transactions between such filer and the
749 holding or parent company or subsidiary that are reasonably related to
750 the subject matter of the filing.

751 Sec. 17. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

752 (1) "General anesthesia" has the same meaning as provided in section
753 20-123a of the general statutes; and

754 (2) "Medical necessity" has the same meaning as provided in section
755 38a-482a of the general statutes.

756 (b) No individual health insurance policy providing coverage of the
757 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
758 of the general statutes delivered, issued for delivery, renewed, amended
759 or continued in this state on or after January 1, 2026, shall (1) if such
760 policy provides coverage for general anesthesia, (A) impose an arbitrary
761 time limit on reimbursement for general anesthesia provided during
762 any medically necessary procedure, or (B) deny, reduce, terminate or

763 fail to provide such reimbursement, in whole or in part, for general
764 anesthesia solely because the duration of care exceeded a predetermined
765 time limit as determined by the insurer, or (2) impose unilateral
766 arbitrary limitations on reimbursement for medically necessary
767 ancillary services.

768 (c) The medical necessity for administering general anesthesia during
769 any medical procedure shall be determined by the attending board-
770 certified anesthesiologist during such medical procedure.

771 Sec. 18. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

772 (1) "General anesthesia" has the same meaning as provided in section
773 20-123a of the general statutes; and

774 (2) "Medical necessity" has the same meaning as provided in section
775 38a-482a of the general statutes.

776 (b) No group health insurance policy providing coverage of the type
777 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
778 the general statutes delivered, issued for delivery, renewed, amended
779 or continued in this state on or after January 1, 2026, shall (1) if such
780 policy provides coverage for general anesthesia, (A) impose an arbitrary
781 time limit on reimbursement for general anesthesia provided during
782 any medically necessary procedure, or (B) deny, reduce, terminate or
783 fail to provide such reimbursement, in whole or in part, for general
784 anesthesia solely because the duration of care exceeded a predetermined
785 time limit as determined by the insurer, or (2) impose unilateral
786 arbitrary limitations on reimbursement for medically necessary
787 ancillary services.

788 (c) The medical necessity for administering general anesthesia during
789 any medical procedure shall be determined by the attending board-
790 certified anesthesiologist during such medical procedure.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>October 1, 2025</i>	New section
Sec. 2	<i>October 1, 2025</i>	38a-477ee(c)
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>October 1, 2025</i>	New section
Sec. 5	<i>January 1, 2026</i>	38a-591c(a) and (b)
Sec. 6	<i>January 1, 2026</i>	38a-591e(c)
Sec. 7	<i>January 1, 2026</i>	38a-510
Sec. 8	<i>January 1, 2026</i>	38a-544
Sec. 9	<i>July 1, 2026</i>	New section
Sec. 10	<i>January 1, 2026</i>	38a-481(a) to (c)
Sec. 11	<i>January 1, 2026</i>	38a-513
Sec. 12	<i>January 1, 2026</i>	38a-183(a)(1)
Sec. 13	<i>January 1, 2026</i>	38a-208(a)
Sec. 14	<i>January 1, 2026</i>	38a-218(a)
Sec. 15	<i>January 1, 2026</i>	New section
Sec. 16	<i>January 1, 2026</i>	New section
Sec. 17	<i>January 1, 2026</i>	New section
Sec. 18	<i>January 1, 2026</i>	New section

Statement of Legislative Commissioners:

In Section 6(c)(1)(C)(i), "subdivision (1)" was changed to "subdivision (2)" for accuracy, in Section 15(c)(4), "executive director of the Office of Health Strategy" was changed to "Commissioner of Health Strategy" for accuracy, and in Section 16(b)(2), "the provisions of" was added after "pursuant to" for consistency.

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:

Agency Affected	Fund-Effect	FY 26 \$	FY 27 \$
State Comptroller - Fringe Benefits, and Various State Agencies	App Fund - Cost	See Below	See Below
State Comptroller - Fringe Benefits, and Various State Agencies	App Fund - Indeterminate	See Below	See Below
UConn Health Ctr.	OF - Revenue Gain/Loss	See Below	See Below
Insurance Dept.	IF - Cost	1.1 million	1.2 million
Insurance Dept.	GF - Potential Revenue Gain	See Below	See Below
Insurance Dept.	GF - Potential Cost	None	218,101

Note: App Fund=All Appropriated Funds; IF=Insurance Fund; GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 26 \$	FY 27 \$
Various Municipalities	Cost	See Below	See Below

Explanation

The bill makes various changes regarding health insurance and patient protection, including establishing a rebuttable presumption for utilization review, which would likely result in a significant cost of approximately \$67.8 million annually to the State Comptroller - Fringe Benefits account. The bill makes various other changes anticipated to result in the fiscal impacts described below.

Sections 1 and 2 require insurers to file an annual certification of compliance with mental health and substance user disorder benefit

reporting requirements to the Insurance Commissioner, who must make these reports, including the names of health carriers, public. This procedural change results in no fiscal impact.

Sections 3 and 4 create a separate, nonlapsing Parity Advancement Account within the General Fund and require the Insurance Department to enforce mental health parity and conduct education, resulting in an annual cost of \$218,101 to the new account, beginning in FY 27. This cost is associated with hiring one Consumer Affairs Associate Insurance Examiner, with an annual salary of \$80,000 and fringe benefits costs of \$32,568, and one Business Office Support Staff, with an annual salary of \$75,000 and fringe benefits costs of \$30,533, to perform the additional responsibilities.

The account will be funded by donations and fines the department may impose on health carriers for failing to comply with reporting. Health carriers can be fined \$100 per participant, up to \$1 million annually, resulting in a revenue gain to the General Fund beginning in FY 26 and annually thereafter. Health carriers may also be fined for late filings. The revenue gain to the account will depend on the number of violations and will be used to enforce mental health parity and education.

Sections 5 and 6 establish a rebuttable presumption that a health care service undergoing utilization review is medically necessary if ordered by a health care professional acting within his or her scope of practice. This would likely result in a significant cost, approximately \$121 million annually across various funds beginning in FY 27 (with half-year costs in FY 26). The General Fund share of these costs within the State Comptroller - Fringe Benefits is approximately \$67.8 million annually.

The cost to the state is associated with increased pharmacy and medical utilization for the state employee health plan (SEHP). Medical claims costs are expected to increase by approximately 20% as more services are deemed "medically necessary" resulting from the change in utilization review methodology. This impact is estimated to be \$92 million annually. The impact of the change in utilization review on

pharmacy benefits is estimated to be \$29 million annually, largely driven by costs related to specialty drugs.

Fully insured municipalities and those participating in the state partnership plan (SPP) are likely to see an increase in premiums to the extent carriers expect to see higher utilization of services. Municipalities enrolled in SPP will likely see costs commensurate with the increase to the SEHP based on their enrollment.

These sections also result in a potential revenue gain annually beginning in FY 26 to UConn Health. The revenue gain would vary based on the procedures and the rates paid by insurers.

Sections 7 and 8 place certain restrictions on the use of step therapy: (1) reduce the duration from 30 days to 20, (2) prohibit the use for prescription drugs used to treat chronic, disabling, or life-threatening diseases or conditions, and (3) prohibit its use for prescription drugs used to treat mental or behavioral health conditions.

There is a potential cost of \$9 million annually across various funds for restrictions (1) and (2) dependent on the impact to premiums for the state employee health plan related to increased prescription drug costs. Restriction (3) does not result in a fiscal impact as the state employee health plan does not require step therapy for mental health conditions. The General Fund share of these costs within the State Comptroller – Fringe Benefits is approximately \$5 million annually.

Step therapy is used as a cost management tool, and its prohibition for prescription drugs to treat a chronic, disabling, or life-threatening condition or disease, as well as reduction for all other prescriptions is likely to be reflected in higher premiums through an increased per member per month cost. These restrictions are estimated to increase costs related to the differential between the lower cost alternative and the drug available after step therapy, as well as overall higher prescription drug spend.

These sections also result in potential costs to various municipalities

that either have fully insured health plans or participate in the partnership plan to the extent higher utilization and prescription drug costs increase plan premiums. The partnership plan would face costs commensurate with the increase to the state employee health plan based on their enrollment.

Section 9 requires health carriers and preferred provider networks that contract with health care providers to pay equal reimbursement rates for certain outpatient services to all providers in a geographic area and regardless of the facility where the services are provided. The section also requires the Department of Insurance to establish said geographic regions and adopt site-neutral regulations. This results in a one-time cost to the Insurance Fund of \$75,000 in FY 26 for costs associated with hiring a consultant.

Additionally, this section results in: (1) an indeterminate cost to the state employee health plan and municipalities on the partnership plan as the bill does not specify the rates; and (2) a revenue loss annually beginning in FY 27 to the UConn Health Center. To the extent this section results in reimbursement rates lower than what UConn Health currently receives in certain settings, there is a revenue loss. Such revenue loss would vary based on: (1) the difference between UConn Health's current reimbursement rates in hospital-based settings and those set pursuant to the bill; and (2) the number of procedures performed.

Section 15 makes numerous changes that result in an Insurance Fund cost of approximately \$1 million in FY 26 and \$1.2 million in FY 27 to the Insurance Department. The section modifies the department's existing rate review process by making a series of changes regarding filing requirements, public transparency, and approval criteria, including adding a fourth criterion prohibiting rate approval if the rate is found to be "unaffordable." The department anticipates 45 additional public hearings each year.

New staffing required by the department for the new transparency and approval criteria requirements includes the addition of six new

positions, at a cost to the Insurance Fund of approximately \$600,000 in FY 26, increasing to an annual cost of \$1.2 million in FY 27. (The lower FY 26 impact reflects the bill's January 1 effective date). The new positions are: one Rate Hearing Division Manager, with an annual salary of \$135,000 and fringe benefits of \$112,401; two Insurance Actuaries and two Insurance Attorneys, with an annual salary of \$110,000 and fringe benefits of \$91,586 each; and one Insurance Paralegal, with an annual salary of \$75,000 and fringe benefits of \$62,445. The total annual salary cost for these six positions is \$650,000 and fringe benefit cost of \$541,190 annually.

In addition, to complete the requirements the department anticipates engaging the services of consulting actuaries and outside counsel at a cost of \$300,000 in FY 26. Further, the cost of including a fourth criterion to the rate review process results in a one-time cost to the Insurance Fund of at least \$100,000 to engage the services of consulting actuaries in FY 26. **Sections 10 - 14** modify various statutes with conforming language.

Sections 17 and 18 prohibit health insurance policies from placing time limits on general anesthesia coverage which does not result in a fiscal impact to the state or municipalities because carriers do not currently impose these restrictions.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sSB 10****AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION.**

TABLE OF CONTENTS:

[SUMMARY](#)[§§ 1–4 — MENTAL HEALTH PARITY](#)

Requires health carriers to annually file a mental health parity compliance certification with the insurance commissioner, makes public a carrier's compliance with mental health parity requirements, establishes the parity advancement account in the General Fund, and allows the insurance commissioner to impose civil penalties and late fees on carriers who fail to comply with mental health parity requirements

[§§ 5 & 6 — MEDICAL NECESSITY REBUTTABLE PRESUMPTION](#)

Establishes a rebuttable presumption that a health care service going through utilization review is medically necessary if ordered by a health care professional acting within his or her scope of practice

[§ 5 — ARTIFICIAL INTELLIGENCE](#)

Prohibits health carriers from using artificial intelligence or other algorithms instead of a clinical peer to evaluate the clinical appropriateness of an adverse determination

[§§ 7 & 8 — STEP THERAPY RESTRICTIONS](#)

Prohibits health carriers from requiring the use of step therapy for prescription drugs used to treat a mental or behavioral health condition or a disabling or life-threatening chronic disease or condition; for other conditions, reduces how long a carrier can require an insured to use step therapy from 30 to 20 days

[§ 9 — SITE NEUTRAL PROVIDER REIMBURSEMENT](#)

Requires health carriers and preferred provider networks that contract with health care providers to pay equal reimbursement rates for certain outpatient services to all providers in a geographic area and regardless of the facility where the services are provided

[§§ 10 – 16 — HEALTH INSURANCE RATE REVIEW PROCESS](#)

Prohibits health insurance rates from being unaffordable, sets a rate review process and timeline, requires the insurance commissioner to hold public hearings on each rate filing, allows the health care advocate and attorney general to be parties to a rate filing hearing, and requires the insurance commissioner to adopt regulations

§§ 17 & 18 — REIMBURSEMENT FOR GENERAL ANESTHESIA

Prohibits health insurance policies from imposing (1) arbitrary time limits on reimbursement for medically necessary general anesthesia or (2) unilateral arbitrary limitations on reimbursement for medically necessary ancillary services

BACKGROUND

SUMMARY

This bill contains provisions on a variety of health insurance topics, including the following:

1. mental health parity compliance and enforcement,
2. rebuttable presumption of the medical necessity of a health care service going through utilization review,
3. the use of artificial intelligence instead of a clinical peer during adverse determination reviews,
4. the use of step therapy protocols for certain prescription drugs,
5. site neutral provider reimbursement rules for outpatient services,
6. health insurance rate review criteria and process, and
7. reimbursements for medically necessary general anesthesia and ancillary services.

A section-by-section analysis follows below.

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

§§ 1–4 — MENTAL HEALTH PARITY

Requires health carriers to annually file a mental health parity compliance certification with the insurance commissioner, makes public a carrier's compliance with mental health

parity requirements, establishes the parity advancement account in the General Fund, and allows the insurance commissioner to impose civil penalties and late fees on carriers who fail to comply with mental health parity requirements

Health Carrier Mental Health Parity Compliance Certification (§ 1)

The bill requires a health carrier (e.g., insurer or HMO), beginning by March 1, 2026, to certify annually to the insurance commissioner for the prior year that the carrier reviewed its administrative practices for compliance with state and federal mental health and substance use disorder benefit requirements. The certification must state whether or not the carrier's review found it complied with the requirements. If it did not comply, the certification must identify each non-compliant practice and actions the carrier will take to come into compliance. The carrier's chief executive and chief medical officers must sign the certification.

By law, health carriers must report annually to the insurance commissioner on their compliance with state and federal mental health and substance use disorder benefit parity requirements (CGS § 38a-477ee). Parity means that a policy's mental health and substance use disorder benefits, including nonquantitative treatment limitations, are applied in a way that is comparable to, and not more stringent than, the way in which the policy treats medical and surgical benefits.

Public Disclosure of Health Carrier's Parity Compliance (§ 2)

The bill makes a health carrier's reported compliance with parity requirements public. By law, after the carriers annually report to the insurance commissioner on their compliance with mental health and substance use disorder parity requirements, the commissioner must report to the Insurance and Real Estate Committee. Current law prohibits the commissioner from naming the carriers in his reports and requires that he not make the carriers' identities public.

The bill eliminates the requirements that the (1) commissioner's annual report on health carriers' compliance with mental health parity laws not name or identify the carriers and (2) carriers' names and identities be confidential and not made public by the commissioner.

Parity Advancement Account (§ 3)

The bill establishes the “parity advancement account” as a separate, nonlapsing General Fund account that must contain money required to be deposited in it as well as any public or private donations.

Beginning with FY 26, the Insurance Department must spend the account funds on enforcing state and federal mental health and substance use disorder benefit reporting requirements, conducting consumer education, and other initiatives that support mental health parity on behalf of consumers.

Mental Health Parity Enforcement, Penalties, and Late Fees (§ 4)

Penalties and Expenses. The bill allows the insurance commissioner to impose civil penalties on a health carrier that fails to comply with the bill’s mental health parity compliance certification requirements or the state and federal mental health and substance use disorder benefit reporting requirements (see § 1 above). The penalty must be up to \$100 per member covered under the carrier’s health insurance policy, capped at \$1 million annually. (Under current law, failure to comply may result in a penalty of up to \$15,000 (CGS § 38a-2).)

Before imposing a penalty, the commissioner must allow the carrier a hearing in accordance with the Uniform Administrative Procedure Act. The commissioner may also order the carrier to pay the commissioner reasonable expenses for any proceedings held.

The bill allows the commissioner to waive a civil penalty if the (1) carrier’s violation was due to reasonable cause and not willful neglect or (2) carrier corrected noncompliance within 30 days after filing a certification noting the noncompliance.

Late Fees. The bill also requires the commissioner to charge a \$100 per day late fee to any carrier that fails to timely file any related mental health parity data, report, certification, or other required information. If a carrier files incomplete information, the commissioner must notify the carrier of what is missing and the date by which the carrier must provide

it. The commissioner must charge a \$100 per day late fee to a carrier that does not meet the set due date.

Account Deposits. Under the bill, the insurance commissioner must deposit all penalties and late fees received in the General Fund's parity advancement account, which the bill establishes (see § 3 above).

EFFECTIVE DATE: October 1, 2025, except for the provision establishing the parity advancement account, which is effective upon passage.

§§ 5 & 6 — MEDICAL NECESSITY REBUTTABLE PRESUMPTION

Establishes a rebuttable presumption that a health care service going through utilization review is medically necessary if ordered by a health care professional acting within his or her scope of practice

The bill establishes a rebuttable presumption that a health care service that is undergoing utilization review is medically necessary if ordered by a health care professional acting within his or her scope of practice. ("Utilization review" is a process to determine if a service is covered under the health benefit plan. It evaluates the medical necessity, appropriateness, efficacy, or efficiency of health care services, health care procedures, or health care settings, and includes prospective, concurrent, or retrospective review (CGS § 38a-591a(39).)

Under the bill, a utilization review company has the burden of proving the health care service under review is not medically necessary (§ 5). With respect to appeals of utilization review adverse determinations (e.g., denials) that were based on medical necessity, a health carrier may rebut the presumption by reasonably substantiating to the clinical peer (e.g., health care professional) reviewing the adverse determination that the service is not medically necessary (§ 6).

§ 5 — ARTIFICIAL INTELLIGENCE

Prohibits health carriers from using artificial intelligence or other algorithms instead of a clinical peer to evaluate the clinical appropriateness of an adverse determination

The bill prohibits health carriers from using artificial intelligence or other algorithms instead of a clinical peer to evaluate the clinical appropriateness of an adverse determination resulting from a utilization

review.

By law, and under the bill, “artificial intelligence” is (1) a set of techniques, including machine learning, designed to approximate a cognitive task or (2) an artificial system that meets certain criteria. These criteria are as follows:

1. performs tasks under varying and unpredictable circumstances without significant human oversight or can learn from experience and improve performance when exposed to data sets;
2. is developed in any context, including software or physical hardware, and solves tasks requiring human-like perception, cognition, planning, learning, communication, or physical action; or
3. is designed to (a) think or act like a human, including a cognitive architecture or neural network, or (b) act rationally, including an intelligent software agent or embodied robot that achieves goals using perception, planning, reasoning, learning, communication, decision-making, or action (CGS § 51-10e).

§§ 7 & 8 — STEP THERAPY RESTRICTIONS

Prohibits health carriers from requiring the use of step therapy for prescription drugs used to treat a mental or behavioral health condition or a disabling or life-threatening chronic disease or condition; for other conditions, reduces how long a carrier can require an insured to use step therapy from 30 to 20 days

The bill limits a health carrier’s use of step therapy. Step therapy is a prescription drug protocol that generally requires patients to try less expensive drugs before higher-cost drugs.

The bill prohibits certain individual and group health insurance policies or contracts from requiring the use of step therapy for (1) drugs used to treat a mental or behavioral health condition or (2) a disabling or life-threatening chronic disease or condition, as long as the drug complies with approved Food and Drug Administration indications. (The bill does not define “disabling or life-threatening chronic disease or condition.”) Current law prohibits health carriers from requiring the

use of step therapy for drugs used to treat (1) stage IV metastatic cancer (indefinitely) or (2) schizophrenia, major depressive disorder, or bipolar disorder (until January 1, 2027).

For drugs prescribed for other conditions, the bill reduces how long a carrier can require an insured to use step therapy from 30 to 20 days.

Under the bill, as under existing law, a patient's provider can deem step therapy clinically ineffective for the patient (immediately for the prohibited conditions or at the end of the waiting period for other conditions), at which point the carrier must cover the drugs prescribed by the provider, as long as they are covered under the insurance policy or contract. If the provider does not consider the step therapy regimen to be ineffective or does not request an override as the law allows, the regimen may be continued.

The bill applies to individual and group health insurance policies or contracts that provide coverage for prescription drugs and are delivered, issued, renewed, amended, or continued by an insurer, hospital or medical service corporation, health care center (i.e. HMO), or other entity.

§ 9 — SITE NEUTRAL PROVIDER REIMBURSEMENT

Requires health carriers and preferred provider networks that contract with health care providers to pay equal reimbursement rates for certain outpatient services to all providers in a geographic area and regardless of the facility where the services are provided

The bill requires health carriers and preferred provider networks that enter into, renew, or amend a contract with a health care provider on or after July 1, 2026, to include in the contract a provision requiring equal reimbursement rates for certain covered outpatient services:

1. for all providers in the same geographic region (as determined by the insurance commissioner), regardless of the provider's employer or affiliation, if the services are reimbursed on a fee-for-services basis or as a standardized bundle of benefits (e.g., per diagnosis, condition, or procedure) and
2. regardless of the facility where the services are provided.

The bill applies to covered outpatient services that use a current procedural terminology evaluation and management (CPT E/M) code, current procedural terminology assessment and management (CPT A/M) code, or drug infusion code.

Additionally, the bill requires the (1) contracts to include a conspicuous statement that they comply with the bill's provisions and (2) insurance commissioner to adopt implementing regulations.

EFFECTIVE DATE: July 1, 2026

§§ 10 – 16 — HEALTH INSURANCE RATE REVIEW PROCESS

Prohibits health insurance rates from being unaffordable, sets a rate review process and timeline, requires the insurance commissioner to hold public hearings on each rate filing, allows the health care advocate and attorney general to be parties to a rate filing hearing, and requires the insurance commissioner to adopt regulations

The bill revises the state's rate review process for health insurance policies and contracts issued by health carriers (e.g., insurers, HMOs, and other entities) that are required to file rates with the insurance commissioner. By law, rates cannot be excessive, inadequate, or unfairly discriminatory. The bill also prohibits rates from being unaffordable. It sets a timeline for the rate review process, and requires the insurance commissioner to (1) hold public hearings on each filing and (2) adopt implementing regulations.

Rate Review Process (§§ 15 & 16)

Beginning on January 1, 2026, the bill requires health carriers to file rates with the commissioner at least 120 days before their proposed effective date. Carriers must include with the rate filing an actuarial memorandum certified by an actuary attesting that the rates comply with state and federal laws and are not excessive. The Insurance Department must post (and update) rate filings on its website within three days after receiving them and allow the public at least 30 days to submit written comments on the filings. The posting must include the date the public comment period ends and instructions for submitting comments.

After the public comment period ends, the insurance commissioner

must hold a public hearing on each filing. He must determine the hearing date within five business days after posting a filing online; conspicuously post the hearing date, time, and place online; notify the carrier of the hearing; and hold the hearing before the rate's proposed effective date at a place and time that is convenient for the public.

Under the bill, the healthcare advocate, attorney general, or both may be parties to a rate filing public hearing. They must be given access to the Insurance Department's rate filing records, and department staff involved in reviewing the filings must cooperate with them. The healthcare advocate and attorney general may (1) summon and examine under oath any witnesses deemed necessary for their review of a rate filing and (2) require the health carrier, its holding or parent company, or its subsidiary to produce records reasonably related to the filing.

The bill prohibits the commissioner from approving a rate that is excessive, inadequate, unfairly discriminatory, or unaffordable (see below). Under the bill, the commissioner must conduct an actuarial review of each filing to determine if the proposed rates were developed using methodologies and assumptions that are actuarially sound and comply with actuarial standards. Within 30 days after the public hearing, the commissioner must issue a written decision to approve, disapprove, or modify the rate filing. The decision must include the factors used to reach the decision. The commissioner must post a decision on the department's website within two days after issuing it.

Excessive, Inadequate, Unfairly Discriminatory, and Unaffordable Definitions

Under the bill, a rate is "excessive" if it is unreasonably high for the insurance provided in relation to the underlying risks and costs after considering the following:

1. the filer's experience;
2. the filer's past and projected costs, including commissions;
3. any transfers of funds to the filer's holding or parent company,

- subsidiary, or affiliate;
4. the filer's rate of return on assets or profitability, as compared to similar filers;
 5. a reasonable margin for profit and contingencies;
 6. public comments received on the filing; and
 7. other factors the commissioner deems relevant.

A rate is "inadequate" if it is unreasonably low for the insurance provided in relation to the underlying risks and costs and its continued use would endanger the filer's solvency.

A rate is "unfairly discriminatory" if the premium charged for a classification is not reasonably related to the underlying risks and costs, resulting in different premiums for insureds with similar risks and costs.

A rate is "unaffordable" if the insurance commissioner determines it is inconsistent with (1) the Connecticut Health Affordability Index (CHAI) that the Office of Health Strategy (OHS) and state comptroller commission or (2) another metric the insurance and OHS commissioners designate. (The CHAI measures the impact of healthcare costs, including premiums and out-of-pocket expenses, on a household's ability to afford all basic needs, like housing, transportation, child care, and groceries. It serves as a tool to help policymakers understand the real costs of healthcare.)

§§ 17 & 18 — REIMBURSEMENT FOR GENERAL ANESTHESIA

Prohibits health insurance policies from imposing (1) arbitrary time limits on reimbursement for medically necessary general anesthesia or (2) unilateral arbitrary limitations on reimbursement for medically necessary ancillary services

The bill prohibits certain individual and group health insurance policies that cover general anesthesia from (1) imposing arbitrary time limits on reimbursement for general anesthesia during a medically necessary procedure or (2) denying, reducing, terminating, or not providing reimbursement for general anesthesia solely because its

duration exceeded the insurer's predetermined time limit for the care. It also prohibits the policies from imposing unilateral arbitrary limitations on reimbursement for medically necessary ancillary services.

The bill requires the attending board-certified anesthesiologist to determine the medical necessity of general anesthesia during a medical procedure.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2026, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Related Bills

SB 11 (§§ 10 & 11), favorably reported by the Human Services Committee, includes the same requirements for medically necessary general anesthesia and ancillary services reimbursements as this bill.

SB 1253 (File 282), favorably reported by the Insurance and Real Estate Committee, allows the insurance commissioner to reduce a health carrier's individual or small employer group health insurance rate filing request by up to two percentage points if the carrier's average approved premium rate increase exceeded the state's health care cost growth benchmark in each of the previous two plan years.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 10 Nay 3 (03/13/2025)