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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

care service is not medically necessary.

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

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

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

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

(b) Each health carrier shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Reimburse the contracting health care provider for a covered outpatient benefit that uses 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 in an amount that does not vary based on the facility where the contracting health care provider provides such benefit; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 heath 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)