General Assembly **Substitute Bill No. 7039**

January Session, 2025

HB07039INS 031425

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

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

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 Subsection (c) of section 38a-479b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

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

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

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

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

once;

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

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

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

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

(C) Not later than thirty days after the receipt of the notice required under subparagraph (A) of this subdivision, a provider may appeal such cancellation, denial or demand in accordance with the procedures provided by such organization, which shall include, but not be limited to, an electronic appeal process. If any such organization fails to notify the provider of such organization's determination of such appeal not later than ten business days after receipt of such appeal from such provider, such appeal shall be construed in favor of such provider. Any demand for the return of full or partial payment shall be stayed during the pendency of such appeal.

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

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

Sec. 2. (*Effective from passage*) (a) Not later than July 1, 2025, the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, or their designees, shall convene a working group to study and make recommendations for legislation related to the compensation of pharmacists licensed under chapter 400j of the general statutes, who provide certain health care services, including, but not limited to, vaccine administration, HIV-related tests, influenza-related tests and the prescribing of contraceptive devices or products approved by the federal Food and Drug Administration. For the purposes of this section, (1) "chain pharmacy" means any community pharmacy that is publicly traded or has not less than six stores located in this state, (2) "HIV-related test" and "influenza-related test" have the same meanings as provided in section 20-633f of the general statutes, (3) "independent pharmacy" means any privately owned pharmacy that has not more than five stores located in this state, (4) "pharmacist" has the same meaning as provided in section 20-571 of the general statutes, and (5) "pharmacy benefits manager" has the same meaning as provided in section 38a-479aaa of the general statutes.

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

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

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

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

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

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

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

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

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

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

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

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

(e) Not later than February 1, 2026, the working group shall submit a report on its findings and legislative recommendations to the joint standing committee of General Assembly having cognizance of matters

relating to insurance, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date the working group submits such report or February 1, 2026, whichever is later.

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

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

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

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

(i) A child or adolescent substance use disorder or a child or adolescent mental disorder, holds (I) a national board certification in child and adolescent psychiatry, or (II) a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable; or

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

treatment of adult substance use disorders or adult mental disorders, as applicable.

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

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

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

(C) Where any health insurer or other entity responsible for providing payment to a participating provider pursuant to a contract between such health insurer or other entity and such participating provider has reason to believe that such participating provider misunderstands such participating provider's in-network or out-of-network status, failure to promptly resolve such misunderstanding.

(NEW) (28) (A) Where any health insurer or other entity responsible for providing payment to a participating provider pursuant to a contract between such health insurer or other entity and such participating provider has reason to believe that such participating provider has a

designated representative or contracting agent, failure of such health insurer or other entity to provide to such designated representative or contracting agent of such participating provider any communication relating to such participating provider's status as a participating provider with such health insurer or other entity; and

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

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

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

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

(F) Timely notify a health care provider or facility, when such health carrier has (i) included such health care provider or facility as a participating provider for any of such health carrier's health benefit plans, **[**of such health care provider's or facility's network participation status**]** (ii) denied such health care provider's or facility's request to be a participating provider for any of such health carrier's health benefit plans, or (iii) made any other change to such health care provider's or facility's status as a participating provider for any of such health carrier's health benefit plans. Any such notification by such health carrier pursuant to clause (ii) or (iii) of this subparagraph shall be in writing and provide an explanation of such denial or other such change to such

health care provider's or facility's status as a participating provider. Any decision made by a health carrier pursuant to the provisions of this subparagraph shall be made in good faith and shall not be based solely on any potential financial impact to such health carrier;

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

INS *Joint Favorable Subst.*