General Assembly

Committee Bill No. 10

January Session, 2025

LCO No. **5342**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

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 (1) 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**]** for a prescribed drug for 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**]** for a prescribed drug for 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. (NEW) (*Effective January 1, 2026*) (a) For the purposes of this section:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that the member or individual has (A) examined an insurance company's books, records, procedures and practices concerning, at a minimum, the company's actuarial assumptions and methods used to establish attachment points and other terms of a stop loss insurance policy for health care or medical benefits, and (B) determined, on the basis of such examination, that the company is in compliance with this section and all regulations adopted under subsection (f) of this section;

(2) "Affordable Care Act" has the same meaning as provided in section 38a-1080 of the general statutes;

(3) "Attachment point" means the dollar value of claims incurred by a policyholder at which the insurer that issues or delivers a medical stop loss insurance policy to the policyholder incurs liability to such policyholder for payment under such medical stop loss insurance policy;

(4) "Expected claims" means the dollar value of claims that, in the absence of a medical stop loss insurance policy, the policyholder of such medical stop loss insurance policy is projected to incur under such policyholder's self-funded employee health benefit plan;

(5) "Large employer" has the same meaning as provided in section 1304 of the Affordable Care Act, as amended from time to time; and

(6) "Small employer" has the same meaning as provided in section 1304 of the Affordable Care Act, as amended from time to time.

(b) (1) Except as provided in subdivision (2) of this subsection, on and after January 1, 2026, no insurance company shall deliver, issue for delivery, renew, amend or continue in this state any stop loss insurance policy for health care or medical benefits under any self-funded employee health benefit plan unless such self-funded employee health benefit plan provides coverage for (A) essential health benefits as required by section 38a-492q of the general statutes, and (B) the group state-mandated coverage requirements under chapter 700c of the general statutes.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, on and after January 1, 2026, any insurance company may deliver, issue for delivery, renew, amend or continue in this state a stop loss insurance policy for health care or medical benefits under any self-funded employee health benefit plan, provided such stop loss insurance policy does not:

(A) Have an annual attachment point for claims incurred per covered individual that is less than fifty thousand dollars;

(B) For a small employer, have an annual aggregate attachment point that is less than fifty thousand dollars, ten thousand dollars multiplied by the number of covered individuals or one hundred twenty per cent of expected claims, whichever is greater;

(C) For a large employer, have an annual aggregate attachment point that is less than one hundred ten per cent of expected claims; or

(D) Provide direct coverage for the health care or medical expenses of an individual.

(c) If an insurance company delivers, issues for delivery, renews, amends or continues any employer's stop loss insurance policy for health care or medical benefits in this state that satisfies the requirements pursuant to subsection (b) of this section, such insurance company shall determine, at least annually, the number of such employer's employees.

(d) The commissioner shall, not less than biennially, compute the attachment points established pursuant to subparagraphs (A) to (C), inclusive, of subdivision (2) of subsection (b) of this section based on the percentage increase, if any, in the most recent calendar year average in the consumer price index for all urban consumers, and publish on the commissioner's Internet web site any change in such attachment point not less than six months before the effective date of any such change in attachment point.

(e) Not later than March fifteenth annually, each insurance company that delivers, issues for delivery, renews, amends or continues an employer's stop loss insurance policy for health care or medical benefits under any self-funded employee health benefit plan that satisfies the provisions of subsection (b) of this section shall submit to the commissioner, in a form and manner prescribed by the commissioner,

an actuarial certification. Each such insurance company shall maintain a copy of such actuarial certification at such insurance company's principal place of business.

(f) The commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 11. 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 16 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 16 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 16 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. 12. 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 16 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 16 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 16 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 16 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. 13. 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 16 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 16 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-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 16 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 16 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. 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 16 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 16 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. 16. (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 17 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 executive director of the Office 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. 17. (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 16 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 16 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 section 16 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 16 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. 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 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. 19. (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*	New section
Sec. 11	*January 1, 2026*	38a-481(a) to (c)
Sec. 12	*January 1, 2026*	38a-513
Sec. 13	*January 1, 2026*	38a-183(a)(1)
Sec. 14	*January 1, 2026*	38a-208(a)
Sec. 15	*January 1, 2026*	38a-218(a)
Sec. 16	*January 1, 2026*	New section
Sec. 17	*January 1, 2026*	New section
Sec. 18	*January 1, 2026*	New section
Sec. 19	*January 1, 2026*	New section

Statement of Purpose:

To: (1) Establish (A) certain reporting requirements and enforcement provisions concerning compliance with mental health and substance use disorder benefit laws, and (B) the parity advancement account; (2) require health carriers to bear the burden of proving that certain health care services under adverse determination or utilization review are not medically necessary; (3) establish certain prohibitions on the use of step therapy for prescription drugs; (4) require health carriers to include

certain provisions in contracts with health care providers regarding reimbursement for certain covered health benefits; (5) establish certain requirements concerning stop loss insurance policies for health care or medical benefits under any self-funded employee health benefit plan; (6) establish certain health insurance rate filing requirements and require that the Insurance Commissioner adopt regulations concerning affordability in rate filing; (7) prohibit the use of artificial intelligence to make an adverse determination based on medical necessity; and (8) prohibit any individual or group health insurance policy from imposing (A) arbitrary time limits on reimbursement for general anesthesia services, or (B) unilateral arbitrary limitations on reimbursement for medically necessary ancillary services.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. DUFF, 25th Dist.
SEN. ANWAR, 3rd Dist.; SEN. CABRERA, 17th Dist.
SEN. COHEN, 12th Dist.; SEN. FLEXER, 29th Dist.
SEN. GADKAR-WILCOX, 22nd Dist.; SEN. GASTON, 23rd Dist.
SEN. HOCHADEL, 13th Dist.; SEN. HONIG, 8th Dist.
SEN. KUSHNER, 24th Dist.; SEN. LESSER, 9th Dist.
SEN. LOPES, 6th Dist.; SEN. MAHER, 26th Dist.
SEN. MARONEY, 14th Dist.; SEN. MARX, 20th Dist.
SEN. MCCRORY, 2nd Dist.; SEN. MILLER P., 27th Dist.
SEN. NEEDLEMAN, 33rd Dist.; SEN. OSTEN, 19th Dist.
SEN. RAHMAN, 4th Dist.; SEN. SLAP, 5th Dist.
SEN. WINFIELD, 10th Dist.; REP. ELLIOTT, 88th Dist.

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