



General Assembly

January Session, 2025

**Committee Bill No. 10**

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:

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

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

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

7 (b) (1) Not later than March 1, 2026, and annually thereafter, each  
8 health carrier shall file a certification with the Insurance Commissioner  
9 for the immediately preceding calendar year, certifying that such health  
10 carrier completed a review of such health carrier's administrative  
11 practices for compliance with the state and federal mental health and  
12 substance use disorder benefit reporting requirements pursuant to  
13 sections 38a-477ee, as amended by this act, 38a-488c, 38a-488d, 38a-514c,  
14 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this act, and 38a-  
15 544 of the general statutes, as amended by this act, and the provisions

16 of the federal Paul Wellstone and Pete Domenici Mental Health Parity  
17 and Addiction Equity Act of 2008, P.L. 110-343, as amended from time  
18 to time, and regulations adopted thereunder. Such certification shall be  
19 signed by the chief executive officer and chief medical officer of such  
20 health carrier.

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

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

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

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

46 [(A)] (1) The joint standing committee of the General Assembly

47 having cognizance of matters relating to insurance, in accordance with  
48 section 11-4a; and

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

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

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

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

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

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

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

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

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

111 section 3 of this act.

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

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

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

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

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

138 (D) For each utilization review, there shall be a rebuttable  
139 presumption that each health care service under review is medically  
140 necessary if such health care service was ordered by a health care

141 professional acting within such health care professional's scope of  
142 practice. Any utilization review company performing such review of a  
143 health care service shall have the burden of proving that such health  
144 care service is not medically necessary.

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

165 (4) For any utilization review for the treatment of a child or  
166 adolescent mental disorder, the clinical review criteria used shall be: (A)  
167 The most recent guidelines of the American Academy of Child and  
168 Adolescent Psychiatry's Child and Adolescent Service Intensity  
169 Instrument; or (B) clinical review criteria that the health carrier  
170 demonstrates to the Insurance Department is consistent with the most  
171 recent guidelines of the American Academy of Child and Adolescent  
172 Psychiatry's Child and Adolescent Service Intensity Instrument, except  
173 that nothing in this subdivision shall prohibit a health carrier from

174 developing its own clinical review criteria or purchasing or licensing  
175 additional clinical review criteria from qualified vendors approved by  
176 the commissioner, to address advancements in technology or types of  
177 care for the treatment of a child or adolescent mental disorder, that are  
178 not covered in the most recent guidelines of the American Academy of  
179 Child and Adolescent Psychiatry's Child and Adolescent Service  
180 Intensity Instrument. Any such clinical review criteria developed by a  
181 health carrier or purchased or licensed from a qualified vendor shall  
182 conform to the requirements of subparagraph (A) of subdivision (2) of  
183 this subsection.

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

204 (b) Each health carrier shall:

205 (1) Have procedures in place to ensure that (A) the health care

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

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

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

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

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

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

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

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



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

240 (C) (i) To effectuate the rebuttable presumption pursuant to  
241 subparagraph (D) of subdivision (1) of subsection (a) of section 38a-591c,  
242 as amended by this act, the health carrier may rebut such presumption  
243 by reasonably substantiating to the clinical peer or peers conducting the  
244 review pursuant to the provisions of this section that such health care  
245 service is not medically necessary.

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

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

265 (2) If the review under subdivision (1) of this subsection is an  
266 expedited review, all necessary information, including the health  
267 carrier's decision, shall be transmitted between the health carrier and the

268 covered person or the covered person's authorized representative, as  
269 applicable, by telephone, facsimile, electronic means or any other  
270 expeditious method available.

271 (3) If the review under subdivision (1) of this subsection is an  
272 expedited review of a grievance involving an adverse determination of  
273 a concurrent review request, pursuant to 45 CFR 147.136, as amended  
274 from time to time, the treatment shall be continued without liability to  
275 the covered person until the covered person has been notified of the  
276 review decision.

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

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

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

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

299 "Diagnostic and Statistical Manual of Mental Disorders", or (D) for a  
300 prescribed drug for the treatment of a mental or behavioral health  
301 condition, provided such prescribed drug is in compliance with  
302 approved federal Food and Drug Administration indications.

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

319 (b) (1) Notwithstanding the [sixty-day] twenty-day period set forth  
320 in subparagraph (A) of subdivision (2) of subsection (a) of this section,  
321 each insurance company, hospital service corporation, medical service  
322 corporation, health care center or other entity that uses step therapy for  
323 such prescription drugs shall establish and disclose to its health care  
324 providers a process by which an insured's treating health care provider  
325 may request at any time an override of the use of any step therapy drug  
326 regimen. Any such override process shall be convenient to use by health  
327 care providers and an override request shall be expeditiously granted  
328 when an insured's treating health care provider demonstrates that the  
329 drug regimen required under step therapy (A) has been ineffective in  
330 the past for treatment of the insured's medical condition, (B) is expected  
331 to be ineffective based on the known relevant physical or mental

332 characteristics of the insured and the known characteristics of the drug  
333 regimen, (C) will cause or will likely cause an adverse reaction by or  
334 physical harm to the insured, or (D) is not in the best interest of the  
335 insured, based on medical necessity.

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

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

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

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

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

355 (2) Require, if such insurance company, hospital service corporation,  
356 medical service corporation, health care center or other entity uses step  
357 therapy for such drugs, the use of step therapy (A) for any prescribed  
358 drug for longer than [thirty] twenty days, (B) [for a prescribed drug for  
359 cancer treatment for an insured who has been diagnosed with stage IV  
360 metastatic cancer] for a prescribed drug for the treatment of a disabling  
361 or life-threatening chronic disease or condition, provided such

362 prescribed drug is in compliance with approved federal Food and Drug  
363 Administration indications, [or] (C) for the period commencing January  
364 1, 2024, and ending January 1, 2027, inclusive, for the treatment of  
365 schizophrenia, major depressive disorder or bipolar disorder, as defined  
366 in the most recent edition of the American Psychiatric Association's  
367 "Diagnostic and Statistical Manual of Mental Disorders", or (D) for a  
368 prescribed drug for the treatment of a mental or behavioral health  
369 condition, provided such prescribed drug is in compliance with  
370 approved federal Food and Drug Administration indications.

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

387 (b) (1) Notwithstanding the [sixty-day] twenty-day period set forth  
388 in subparagraph (A) of subdivision (2) of subsection (a) of this section,  
389 each insurance company, hospital service corporation, medical service  
390 corporation, health care center or other entity that uses step therapy for  
391 such prescription drugs shall establish and disclose to its health care  
392 providers a process by which an insured's treating health care provider  
393 may request at any time an override of the use of any step therapy drug  
394 regimen. Any such override process shall be convenient to use by health

395 care providers and an override request shall be expeditiously granted  
396 when an insured's treating health care provider demonstrates that the  
397 drug regimen required under step therapy (A) has been ineffective in  
398 the past for treatment of the insured's medical condition, (B) is expected  
399 to be ineffective based on the known relevant physical or mental  
400 characteristics of the insured and the known characteristics of the drug  
401 regimen, (C) will cause or will likely cause an adverse reaction by or  
402 physical harm to the insured, or (D) is not in the best interest of the  
403 insured, based on medical necessity.

404 (2) Upon the granting of an override request, the insurance company,  
405 hospital service corporation, medical service corporation, health care  
406 center or other entity shall authorize dispensation of and coverage for  
407 the drug prescribed by the insured's treating health care provider,  
408 provided such drug is a covered drug under such policy or contract.

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

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

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

422 (A) Reimburse the contracting health care provider for a covered  
423 outpatient benefit that uses a current procedural terminology  
424 evaluation and management (CPT E/M) code, current procedural  
425 terminology assessment and management (CPT A/M) code or drug

426 infusion code in an amount that does not vary based on the facility  
427 where the contracting health care provider provides such benefit; and

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

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

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

444 Sec. 10. (NEW) (*Effective January 1, 2026*) (a) For the purposes of this  
445 section:

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

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

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

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

467 (5) "Large employer" has the same meaning as provided in section  
468 1304 of the Affordable Care Act, as amended from time to time; and

469 (6) "Small employer" has the same meaning as provided in section  
470 1304 of the Affordable Care Act, as amended from time to time.

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

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



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

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

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

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

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

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

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

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

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

522 Sec. 11. Subsections (a) to (c), inclusive, of section 38a-481 of the  
523 general statutes are repealed and the following is substituted in lieu  
524 thereof (*Effective January 1, 2026*):

525 (a) No individual health insurance policy shall be delivered or issued  
526 for delivery to any person in this state, nor shall any application, rider  
527 or endorsement be used in connection with such policy, until a copy of  
528 the form thereof and of the classification of risks and the premium rates  
529 have been filed with the commissioner. Rate filings shall include the  
530 information and data required under section 38a-479qqq if the policy is  
531 subject to said section, and an actuarial memorandum that includes, but  
532 is not limited to, pricing assumptions and claims experience, the  
533 requirements established in section 16 of this act, and premium rates  
534 and loss ratios from the inception of the policy. Each premium rate filed  
535 on or after January 1, 2021, shall, if the insurer intends to account for  
536 rebates, as defined in section 38a-479ooo in the manner specified in  
537 section 38a-479rrr, account for such rebates in such manner, if the policy  
538 is subject to section 38a-479rrr. The commissioner may adopt  
539 regulations, in accordance with the provisions of chapter 54, to establish  
540 a procedure for reviewing such policies. The commissioner shall  
541 disapprove the use of such form at any time if it does not comply with  
542 the requirements of law, or if it contains a provision or provisions that  
543 are unfair or deceptive or that encourage misrepresentation of the  
544 policy. The commissioner shall notify, in writing, the insurer that has  
545 filed any such form of the commissioner's disapproval, specifying the  
546 reasons for disapproval, and ordering that no such insurer shall deliver  
547 or issue for delivery to any person in this state a policy on or containing

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

552 (b) (1) No rate filed under the provisions of subsection (a) of this  
553 section shall be effective until it has been approved by the commissioner  
554 in accordance with regulations adopted pursuant to this subsection. The  
555 commissioner shall adopt regulations, in accordance with the  
556 provisions of chapter 54, to prescribe standards to ensure that such rates  
557 shall not be excessive, inadequate, [or] unfairly discriminatory [. The  
558 commissioner may disapprove such rate if it fails to comply with such  
559 standards, except that no rate filed under the provisions of subsection  
560 (a) of this section for any Medicare supplement policy shall be effective  
561 unless approved in accordance with section 38a-474] or unaffordable  
562 pursuant to the provisions of section 16 of this act.

563 (2) Any rate filed in accordance with the provisions of subsection (a)  
564 of this section for health insurance that provides coverage of the type  
565 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall  
566 be approved in accordance with the provisions of section 16 of this act.

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

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

578 Sec. 12. Section 38a-513 of the general statutes is repealed and the

579 following is substituted in lieu thereof (*Effective January 1, 2026*):

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

597 (b) (1) No rate filed in accordance with the provisions of subsection  
598 (a) of this section shall be effective until such rate has been approved by  
599 the commissioner in accordance with regulations adopted pursuant to  
600 this subsection or as provided under subdivision (2) of this subsection.  
601 The commissioner shall adopt regulations, in accordance with the  
602 provisions of chapter 54, to prescribe standards to ensure that such rates  
603 shall not be excessive, inadequate, unfairly discriminatory or  
604 unaffordable pursuant to the provisions of section 16 of this act.

605 (2) Any rate filed in accordance with the provisions of subsection (a)  
606 of this section for a group health insurance policy that provides  
607 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
608 of section 38a-469 shall be approved in accordance with the provisions  
609 of section 16 of this act.

610 [(2)] (c) No group health insurance policy or certificate for a small

611 employer, as defined in section 38a-564, shall be delivered or issued for  
612 delivery in this state unless the premium rates have been submitted to  
613 and approved by the commissioner in accordance with the provisions  
614 of section 16 of this act. Premium rate filings shall include the  
615 information and data required under section 38a-479qqq if the policy is  
616 subject to said section, and an actuarial memorandum that includes, but  
617 is not limited to, pricing assumptions and claims experience, the  
618 requirements set forth in section 16 of this act, and premium rates and  
619 loss ratios from the inception of the policy. Each premium rate filed on  
620 or after January 1, 2021, shall, if the insurer intends to account for  
621 rebates, as defined in section 38a-479ooo in the manner specified in  
622 section 38a-479rrr, account for such rebates in such manner, if the policy  
623 is subject to section 38a-479rrr. As used in this subdivision, "loss ratio"  
624 means the ratio of incurred claims to earned premiums by the number  
625 of years of policy duration for all combined durations.

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

634       [(c)] (e) Nothing in this chapter shall preclude the issuance of a group  
635 health insurance policy that includes an optional life insurance rider,  
636 provided the optional life insurance rider shall be filed with and  
637 approved by the Insurance Commissioner pursuant to section 38a-430.  
638 Any company offering such policies for sale in this state shall be licensed  
639 to sell life insurance in this state pursuant to the provisions of section  
640 38a-41.

641       [(d)] (f) Not later than January 1, 2009, the commissioner shall adopt  
642 regulations, in accordance with chapter 54, to establish minimum

643 standards for benefits in group specified disease policies, certificates,  
644 riders, endorsements and benefits.

645 Sec. 13. Subdivision (1) of subsection (a) of section 38a-183 of the  
646 general statutes is repealed and the following is substituted in lieu  
647 thereof (*Effective January 1, 2026*):

648 (a) (1) A health care center governed by sections 38a-175 to 38a-194,  
649 inclusive, shall not enter into any agreement with subscribers unless and  
650 until [it] such health care center has filed with the commissioner a full  
651 schedule of the amounts to be paid by the subscribers and has obtained  
652 the commissioner's approval [thereof] in accordance with the provisions  
653 of section 16 of this act. Such filing shall include the information and  
654 data required under section 38a-479qqq if the contract or policy is  
655 subject to said section, and an actuarial memorandum that includes, but  
656 is not limited to, pricing assumptions and claims experience, and  
657 premium rates and loss ratios from the inception of the contract or  
658 policy. The commissioner [may refuse such approval if the  
659 commissioner finds such amounts to] shall adopt regulations, in  
660 accordance with the provisions of chapter 54, to prescribe standards to  
661 ensure that such amounts shall not be excessive, inadequate, [or]  
662 discriminatory or unaffordable pursuant to the provisions of section 16  
663 of this act. As used in this subsection, "loss ratio" means the ratio of  
664 incurred claims to earned premiums by the number of years of policy  
665 duration for all combined durations.

666 Sec. 14. Subsection (a) of section 38a-208 of the general statutes is  
667 repealed and the following is substituted in lieu thereof (*Effective January*  
668 *1, 2026*):

669 (a) No such corporation shall enter into any contract with subscribers  
670 unless and until it has filed with the Insurance Commissioner a full  
671 schedule of the rates to be paid by the subscribers and has obtained said  
672 commissioner's approval [thereof] in accordance with the provisions of  
673 section 16 of this act. Such filing shall include an actuarial memorandum  
674 that includes, but is not limited to, pricing assumptions and claims

675 experience, and premium rates and loss ratios from the inception of the  
676 contract. The commissioner [may refuse such approval if the  
677 commissioner finds such rates to] shall adopt regulations, in accordance  
678 with the provisions of chapter 54, to prescribe standards to ensure that  
679 such amounts shall not be excessive, inadequate, [or] discriminatory or  
680 unaffordable pursuant to the provisions of section 16 of this act. As used  
681 in this subsection, "loss ratio" means the ratio of incurred claims to  
682 earned premiums by the number of years of policy duration for all  
683 combined durations.

684 Sec. 15. Subsection (a) of section 38a-218 of the general statutes is  
685 repealed and the following is substituted in lieu thereof (*Effective January*  
686 *1, 2026*):

687 (a) No such medical service corporation shall enter into any contract  
688 with subscribers unless and until it has filed with the Insurance  
689 Commissioner a full schedule of the rates to be paid by the subscriber  
690 and has obtained said commissioner's approval [thereof] in accordance  
691 with the provisions of section 16 of this act. Such filing shall include an  
692 actuarial memorandum that includes, but is not limited to, pricing  
693 assumptions and claims experience, and premium rates and loss ratios  
694 from the inception of the contract. The commissioner [may refuse such  
695 approval if the commissioner finds such rates are] shall adopt  
696 regulations, in accordance with the provisions of chapter 54, to prescribe  
697 standards to ensure that such amounts shall not be excessive,  
698 inadequate, [or] discriminatory or unaffordable pursuant to the  
699 provisions of section 16 of this act. As used in this subsection, "loss ratio"  
700 means the ratio of incurred claims to earned premiums by the number  
701 of years of policy duration for all combined durations.

702 Sec. 16. (NEW) (*Effective January 1, 2026*) (a) (1) With respect to a  
703 health insurance policy, agreement or contract that provides coverage  
704 of the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
705 38a-469 of the general statutes, any (A) rate filed for such policy  
706 pursuant to section 38a-481 of the general statutes, as amended by this

707 act, (B) rate filed for such policy pursuant to section 38a-513 of the  
708 general statutes, as amended by this act, (C) schedule of amounts filed  
709 for such agreement pursuant to section 38a-183 of the general statutes,  
710 as amended by this act, (D) schedule of rates filed for such contract  
711 pursuant to section 38a-208 of the general statutes, as amended by this  
712 act, or (E) schedule of rates filed for such contract pursuant to section  
713 38a-218 of the general statutes, as amended by this act, on or after  
714 January 1, 2026, shall be filed not later than one hundred twenty  
715 calendar days prior to the proposed effective date of such rates or  
716 amounts.

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

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



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

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

754 (2) Such public hearing shall be (A) held after the end of the public  
755 comment period specified in subparagraph (B) of subdivision (3) of  
756 subsection (a) of this section, but not later than prior to the proposed  
757 effective date of such rate or amount, at a place and time that is  
758 convenient to the public, and (B) conducted in accordance with the  
759 provisions of chapter 54 of the general statutes, this section and section  
760 17 of this act.

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

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

772 (1) Any rate or amount shall be considered excessive if it is  
773 unreasonably high for the insurance provided in relation to the  
774 underlying risks and costs after due consideration of: (A) The  
775 experience of such filer; (B) such filer's past and projected costs,  
776 including amounts to be paid for commissions; (C) any transfers of  
777 funds to the holding or parent company, subsidiary or affiliate of such  
778 filer; (D) such filer's rate of return on assets or profitability, as compared  
779 to similar filers; (E) a reasonable margin for profit and contingencies; (F)  
780 any public comments received on such filing in accordance with the  
781 provisions of subparagraph (B) of subdivision (3) of subsection (a) of  
782 this section; and (G) other factors the commissioner deems relevant.

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

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

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

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

804 commissioner issues such decision.

805       Sec. 17. (NEW) (*Effective January 1, 2026*) (a) Notwithstanding sections  
806 4-176 and 4-177a of the general statutes, the Healthcare Advocate or the  
807 Attorney General, or both, may be parties to any public hearing held in  
808 accordance with the provisions of section 16 of this act.

809       (b) Subject to the provisions of section 4-181 of the general statutes,  
810 (1) the Healthcare Advocate or the Attorney General, or both, shall have  
811 access to the records of the Insurance Department regarding any rate or  
812 amount filing made in accordance with the provisions of section 16 of  
813 this act, and (2) attorneys, actuaries, accountants and other experts who  
814 are part of the Insurance Commissioner's staff and who review or assist  
815 in the determination of such filing pursuant to section 16 of this act shall  
816 cooperate with the Healthcare Advocate or Attorney General, or both,  
817 to carry out the provisions of this section.

818       (c) The Healthcare Advocate or the Attorney General, or both, may  
819 (1) summon and examine under oath such witnesses as the Healthcare  
820 Advocate or the Attorney General deems necessary for the review of a  
821 rate or amount filing made in accordance with the provisions of section  
822 16 of this act, and (2) require the filer or any holding or parent company  
823 or subsidiary of such filer to produce books, vouchers, memoranda,  
824 papers, letters, contracts and other documents, regardless of the format  
825 in which such materials are stored. Any such books, vouchers,  
826 memoranda, papers, letters, contracts or other documents shall be  
827 limited to such information or transactions between such filer and the  
828 holding or parent company or subsidiary that are reasonably related to  
829 the subject matter of the filing.

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

831       (1) "General anesthesia" has the same meaning as provided in section  
832 20-123a of the general statutes; and

833       (2) "Medical necessity" has the same meaning as provided in section

834 38a-482a of the general statutes.

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

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

850 Sec. 19. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

851 (1) "General anesthesia" has the same meaning as provided in section  
852 20-123a of the general statutes; and

853 (2) "Medical necessity" has the same meaning as provided in section  
854 38a-482a of the general statutes.

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

864 time limit as determined by the insurer, or (2) impose unilateral  
 865 arbitrary limitations on reimbursement for medically necessary  
 866 ancillary services.

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

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

Section 1	<i>October 1, 2025</i>	New section
Sec. 2	<i>October 1, 2025</i>	38a-477ee(c)
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>October 1, 2025</i>	New section
Sec. 5	<i>January 1, 2026</i>	38a-591c(a) and (b)
Sec. 6	<i>January 1, 2026</i>	38a-591e(c)
Sec. 7	<i>January 1, 2026</i>	38a-510
Sec. 8	<i>January 1, 2026</i>	38a-544
Sec. 9	<i>July 1, 2026</i>	New section
Sec. 10	<i>January 1, 2026</i>	New section
Sec. 11	<i>January 1, 2026</i>	38a-481(a) to (c)
Sec. 12	<i>January 1, 2026</i>	38a-513
Sec. 13	<i>January 1, 2026</i>	38a-183(a)(1)
Sec. 14	<i>January 1, 2026</i>	38a-208(a)
Sec. 15	<i>January 1, 2026</i>	38a-218(a)
Sec. 16	<i>January 1, 2026</i>	New section
Sec. 17	<i>January 1, 2026</i>	New section
Sec. 18	<i>January 1, 2026</i>	New section
Sec. 19	<i>January 1, 2026</i>	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.

S.B. 10