



General Assembly

## ***Substitute Bill No. 10***

*January Session, 2025*



### ***AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION.***

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

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

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

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

7       (b) (1) Not later than March 1, 2026, and annually thereafter, each  
8       health carrier shall file a certification with the Insurance Commissioner  
9       for the immediately preceding calendar year, certifying that such health  
10      carrier completed a review of such health carrier's administrative  
11      practices for compliance with the state and federal mental health and  
12      substance use disorder benefit reporting requirements pursuant to  
13      sections 38a-477ee, as amended by this act, 38a-488c, 38a-488d, 38a-514c,  
14      38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this act, and 38a-  
15      544 of the general statutes, as amended by this act, and the provisions  
16      of the federal Paul Wellstone and Pete Domenici Mental Health Parity  
17      and Addiction Equity Act of 2008, P.L. 110-343, as amended from time

18 to time, and regulations adopted thereunder. Such certification shall be  
19 signed by the chief executive officer and chief medical officer of such  
20 health carrier.

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

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

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

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

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

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

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

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

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

79 (2) The commissioner may order the payment of such reasonable  
80 expenses as may be necessary to compensate the commissioner in

81 conjunction with any proceedings under this section, which shall be  
82 dedicated to the enforcement and implementation of the state and  
83 federal mental health parity laws and regulations adopted thereunder.

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

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

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

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

112 Sec. 5. Subsections (a) and (b) of section 38a-591c of the general

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

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

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

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

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

138 (D) For each utilization review, there shall be a rebuttable  
139 presumption that each health care service under review is medically  
140 necessary if such health care service was ordered by a health care  
141 professional acting within such health care professional's scope of  
142 practice. Any utilization review company performing such review of a  
143 health care service shall have the burden of proving that such health  
144 care service is not medically necessary.

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

165       (4) For any utilization review for the treatment of a child or  
166 adolescent mental disorder, the clinical review criteria used shall be: (A)  
167 The most recent guidelines of the American Academy of Child and  
168 Adolescent Psychiatry's Child and Adolescent Service Intensity  
169 Instrument; or (B) clinical review criteria that the health carrier  
170 demonstrates to the Insurance Department is consistent with the most  
171 recent guidelines of the American Academy of Child and Adolescent  
172 Psychiatry's Child and Adolescent Service Intensity Instrument, except  
173 that nothing in this subdivision shall prohibit a health carrier from  
174 developing its own clinical review criteria or purchasing or licensing  
175 additional clinical review criteria from qualified vendors approved by  
176 the commissioner, to address advancements in technology or types of  
177 care for the treatment of a child or adolescent mental disorder, that are  
178 not covered in the most recent guidelines of the American Academy of

179 Child and Adolescent Psychiatry's Child and Adolescent Service  
180 Intensity Instrument. Any such clinical review criteria developed by a  
181 health carrier or purchased or licensed from a qualified vendor shall  
182 conform to the requirements of subparagraph (A) of subdivision (2) of  
183 this subsection.

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

204 (b) Each health carrier shall:

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

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

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

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

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

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

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

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

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

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



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

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

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

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

271     (3) If the review under subdivision (1) of this subsection is an  
272 expedited review of a grievance involving an adverse determination of

273 a concurrent review request, pursuant to 45 CFR 147.136, as amended  
274 from time to time, the treatment shall be continued without liability to  
275 the covered person until the covered person has been notified of the  
276 review decision.

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

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

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

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

303 (3) At the expiration of the time period specified in subparagraph (A)  
304 of subdivision (2) of this subsection or for a prescribed drug described

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

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

336 (2) Upon the granting of an override request, the insurance company,  
337 hospital service corporation, medical service corporation, health care  
338 center or other entity shall authorize dispensation of and coverage for

339 the drug prescribed by the insured's treating health care provider,  
340 provided such drug is a covered drug under such policy or contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

567 Sec. 12. Subdivision (1) of subsection (a) of section 38a-183 of the  
568 general statutes is repealed and the following is substituted in lieu  
569 thereof (*Effective January 1, 2026*):

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

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

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

600 with the provisions of chapter 54, to prescribe standards to ensure that  
601 such amounts shall not be excessive, inadequate, [or] discriminatory or  
602 unaffordable pursuant to the provisions of section 15 of this act. As used  
603 in this subsection, "loss ratio" means the ratio of incurred claims to  
604 earned premiums by the number of years of policy duration for all  
605 combined durations.

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

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

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

633 pursuant to section 38a-208 of the general statutes, as amended by this  
634 act, or (E) schedule of rates filed for such contract pursuant to section  
635 38a-218 of the general statutes, as amended by this act, on or after  
636 January 1, 2026, shall be filed not later than one hundred twenty  
637 calendar days prior to the proposed effective date of such rates or  
638 amounts.

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

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

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

666 comments to the department.

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

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

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

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

694 (1) Any rate or amount shall be considered excessive if it is  
695 unreasonably high for the insurance provided in relation to the  
696 underlying risks and costs after due consideration of: (A) The  
697 experience of such filer; (B) such filer's past and projected costs,

698 including amounts to be paid for commissions; (C) any transfers of  
699 funds to the holding or parent company, subsidiary or affiliate of such  
700 filer; (D) such filer's rate of return on assets or profitability, as compared  
701 to similar filers; (E) a reasonable margin for profit and contingencies; (F)  
702 any public comments received on such filing in accordance with the  
703 provisions of subparagraph (B) of subdivision (3) of subsection (a) of  
704 this section; and (G) other factors the commissioner deems relevant.

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

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

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

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

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

730 (b) Subject to the provisions of section 4-181 of the general statutes,  
731 (1) the Healthcare Advocate or the Attorney General, or both, shall have  
732 access to the records of the Insurance Department regarding any rate or  
733 amount filing made in accordance with the provisions of section 15 of  
734 this act, and (2) attorneys, actuaries, accountants and other experts who  
735 are part of the Insurance Commissioner's staff and who review or assist  
736 in the determination of such filing pursuant to the provisions of section  
737 15 of this act shall cooperate with the Healthcare Advocate or Attorney  
738 General, or both, to carry out the provisions of this section.

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

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

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

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

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



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

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

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

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

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

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

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

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

**Statement of Legislative Commissioners:**

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

**INS**      *Joint Favorable Subst.*