OLR Bill Analysis

sHB 7039

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

SUMMARY

This bill makes several changes to health insurance statutes. Principally, it does the following:

1. shortens, from 18 to 12 months, the time period during which contracting organizations (e.g., insurers, HMOs, and preferred provider networks) may cancel, deny, or demand the return of payment from a health care provider for an authorized covered service due to an administrative or eligibility error, and requires the organization to have an electronic appeal process in place;

2. for purposes of insurance adverse determination reviews, generally allows someone to serve as a clinical peer if he or she has substantial experience or expertise as a health care professional typically managing the condition under review; and

3. makes a health carrier's (a) violation of network adequacy requirements or (b) specified actions toward health care providers participating in the carrier's provider network (e.g., not acting in good faith when making network decisions and not adhering to a written agreement's provisions) punishable as unfair insurance practices.

Lastly, the bill requires the Insurance and Real Estate Committee's chairpersons, or their designees, to convene an 11-member working group by July 1, 2025, to study compensating pharmacists who provide health care services (e.g., HIV and influenza testing, administering

vaccines, and prescribing contraception). The group must report its findings and legislative recommendations to the committee by February 1, 2026.

EFFECTIVE DATE: October 1, 2025, except the provisions on the (1) return of provider payments and clinical peers are effective January 1, 2026, and (2) working group are effective upon passage.

§ 1 — THE RETURN OF HEALTH CARE PROVIDER PAYMENTS

The bill prohibits a contracting health organization, more than 12 months after receiving a clean (i.e. complete) claim (instead of 18 months as under current law), from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, unless the:

1. organization (a) has a documented basis to believe that the provider fraudulently submitted the claim, (b) already paid the provider for the claim, or (c) paid a claim that should have been or was paid by a federal or state program; or

2. provider (a) did not bill the claim appropriately based on documentation or evidence of what medical service was actually provided or (b) received payment from a different insurer, payor, or administrator through coordination of benefits or subrogation or due to coverage under an automobile insurance or workers' compensation policy.

By law, a contracting health organization must give a provider at least 30 days' advance notice of a payment cancellation, denial, or return demand. Current law requires the notice to be sent by mail, e-mail, or fax. The bill instead requires the organization to provide notice by certified mail, return receipt requested; e-mail to an e-mail address the provider designated; or fax.

Current law allows a provider to appeal a payment cancellation, denial, or return demand within 30 days after receiving notice of it, in accordance with the organization's procedures. The bill specifies that an organization's procedures must include an electronic appeal process.

The bill also requires an organization to notify the provider of its appeal decision within 10 business days after receiving the appeal. If it fails to meet this deadline, the appeal is construed in favor of the provider.

§ 2 — WORKING GROUP ON COMPENSATING PHARMACISTS

The bill requires the Insurance and Real Estate Committee's chairpersons, or their designees, to convene an 11-member working group by July 1, 2025, to study and make legislative recommendations for compensating licensed pharmacists who provide health care services (e.g., HIV and influenza testing, administering vaccines, and prescribing contraception).

Required Membership

The bill requires the working group to consist of the following members:

1. the Insurance and Real Estate Committee chairpersons and ranking members, or their designees;

2. the insurance and consumer protection commissioners, or their designees;

3. two Connecticut-licensed pharmacists, one employed by an independent pharmacy (i.e. a privately owned pharmacy with up to five stores in the state) and one employed by a chain pharmacy (i.e. a community pharmacy that is publicly traded or has at least six stores in the state); and

4. one representative from each of the following: an organization representing pharmacy benefit managers, a health insurer doing business in the state, and a pharmaceutical company doing business in the state.

The bill requires all initial appointments to the working group to be made within 30 days after the bill's effective date. (Presumably the Insurance and Real Estate Committee chairpersons, or their designees, appoint the members, as they must convene the group.)

The bill also requires the Insurance and Real Estate Committee's administrative staff to be the working group's administrative staff.

The working group must report its findings and legislative recommendations to the Insurance and Real Estate Committee by February 1, 2026. It terminates when it submits its report or on February 1, 2026, whichever is later.

§ 3 — CLINICAL PEER QUALIFICATIONS

Under PA 24-19 (§ 32), beginning January 1, 2026, clinical peers doing adverse determination reviews generally must have a nonrestricted license (in any U.S. state) in the same specialty that typically manages the medical condition, procedure, or treatment under review. (Until that time, a clinical peer generally must have a nonrestricted license in the same or similar specialty.)

Beginning January 1, 2026, the bill instead generally requires these clinical peers to have (1) a nonrestricted license in the same specialty as the treating physician or other health care professional who is managing the condition, procedure, or treatment under review or (2) substantial experience or expertise as a treating physician or other health care professional who typically manages the condition, procedure, or treatment under review. However, only a physician may be a clinical peer when the health care professional managing the condition, procedure, or treatment under review is a physician.

By law, unchanged by the bill, for urgent care requests involving substance use or mental health disorders under certain circumstances, the clinical peer must be a (1) psychologist with relevant training and clinical experience or (2) psychiatrist.

§§ 4 & 5 — CUIPA VIOLATIONS FOR CERTAIN CARRIER CONDUCT

By law, carriers must timely notify a health care provider when the carrier includes the provider in its provider network. The bill also requires carriers to timely notify a provider in writing when the carrier has (1) denied the provider's request to join the carrier's network or (2) made any change to the provider's network status for any of the carrier's

health benefit plans. These notifications must explain the denial or other change. The bill also requires a health carrier to make any decisions about a provider's network status in good faith and not solely based on any potential financial impacts to the carrier.

The bill makes the following carrier actions unfair insurance practices under the Connecticut Unfair Insurance Practices Act (CUIPA) (see BACKGROUND):

1. failure by a health carrier to make decisions in good faith based on its provider network's composition, including accepting or denying a provider as a participating provider;

2. failure to give written notice to a participating provider and his or her designated representative of any decision that impacts the provider's network status, including an explanation of the decision;

3. failure to promptly resolve any misunderstanding between the health carrier and a provider about the provider's network status;

4. failure to give a provider's designated representative or contracting agent communications about the provider's network status;

5. attempting to interfere with the relationship between a participating provider and his or her designated representative or contracting agent; and

6. failure by a health carrier to adhere to the provisions of a written agreement or fee schedule in place with a participating provider or network of providers, or attempting to circumvent or misrepresent a written agreement or fee schedule.

Additionally, the bill makes a violation of the state's network adequacy and continuity of care statute (see BACKGROUND) a CUIPA violation.

BACKGROUND

CUIPA

CUIPA prohibits engaging in unfair or deceptive acts or practices in the business of insurance. It authorizes the insurance commissioner to conduct investigations and hearings, issue cease and desist orders, impose fines, revoke or suspend licenses, and order restitution for per se violations (i.e. violations specifically listed in statute). The law also allows the commissioner to ask the attorney general to seek injunctive relief in Superior Court if he believes someone is engaging in other unfair or deceptive acts not specifically defined in statute.

Fines may be up to (1) $5,000 per violation to a $50,000 maximum or (2) $25,000 per violation to a $250,000 maximum in any six-month period if the violation was knowingly committed. The law also imposes a fine of up to $50,000, in addition to or in lieu of a license suspension or revocation, for violating a cease and desist order (CGS §§ 38a-815 to -819).

Network Adequacy and Continuity of Care

Under the network adequacy statute, a health carrier must establish and maintain a network that includes a sufficient number and appropriate types of participating providers, including those that serve predominantly low-income, medically underserved people, to assure that all covered benefits will be accessible to all the carrier's covered persons without unreasonable travel or delay. Covered persons must have access to emergency services and, if urgent crisis center services are available, urgent crisis center services, 24 hours a day, seven days a week.

The law requires health carriers to (1) make a good faith effort to give written notice to the patients of a participating provider who is leaving the carrier's network and (2) provide for the continuity of care for patients in active courses of treatment with the provider so as to allow them to continue their treatments and transition to different participating providers.

It also generally requires health carriers and hospitals involved in a

contract dispute to continue to abide by the terms of their contract, including reimbursement terms, for 60 days after it expires or terminates (CGS § 38a-472f).

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 10 Nay 3 (03/13/2025)