OLR Bill Analysis

HB 7079 (as amended by House "A")*

AN ACT CONCERNING INSURANCE REGULATION IN THE STATE.

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SUMMARY

This bill makes changes to insurance-related statutes, establishes two

working groups, and requires the insurance commissioner to conduct two studies. A section-by-section analysis follows below.

*House Amendment "A" strikes the underlying bill, which would have required the insurance commissioner to study insurance regulation in the state, and replaces it with the provisions summarized below.

EFFECTIVE DATE: Various, see below.

§ 1 — FISCAL NOTES AND ENROLLEE IMPACT STATEMENTS

Requires a bill's fiscal note to include an enrollee impact statement if the bill would impact premiums paid by Access Health CT plan enrollees

The bill requires a legislative fiscal note for any bill that, if passed, would impact the premiums paid by enrollees of health benefit plans offered on the Connecticut Health Insurance Exchange (i.e. Access Health CT). These fiscal notes must include an enrollee impact statement, which the Office of Fiscal Analysis must prepare. The statement must (1) assess if the bill will have a significant direct financial impact to the enrollees' premium costs and (2) clearly identify the cost and revenue impact to premiums in the current fiscal year and the next fiscal year.

EFFECTIVE DATE: January 1, 2026

§ 2 — MUNICIPAL VOLUNTEER FIRE DEPARTMENTS AND AMBULANCE SERVICES HEALTH INSURANCE

Allows municipalities to pay a portion of the premium for its employee group insurance plan for active members of its volunteer fire department and ambulance service

The bill allows municipalities to pay a portion of the premium for its employee group insurance plan for active members of its volunteer fire department and ambulance service who elect to participate in the plan.

Under current law, a municipality may allow active members of these volunteer organizations to join its employee group insurance plan if the volunteer (1) elects to enroll in the plan, (2) agrees to pay 100% of the premium charged and any additional costs, and (3) meets the town's requirements for active status. The bill allows the municipality and the volunteer to negotiate the percentage of the premium the volunteer

would pay rather than requiring the volunteer to pay 100%.

The bill applies to any town, city, or borough that provides employees with group life, health, accident, and hospital plan benefits.

EFFECTIVE DATE: October 1, 2025

Background — Related Bill

HB 6973 (File 355), reported favorably by the Insurance and Real Estate Committee, contains an identical provision on municipal health insurance premiums for volunteer fire departments and ambulance services.

§ 3 — RETURN OF PROVIDER PAYMENTS

Shortens, from 18 to 15 months, the 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; requires an organization to have an electronic appeal process; requires an organization to notify the provider of its appeal decision within 15 business days

The bill prohibits a contracting health organization, more than 15 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 15 business days after receiving the appeal. If it fails to meet this deadline, the appeal is construed in favor of the provider.

EFFECTIVE DATE: January 1, 2026

Background — Related Bill

sHB 7039 (File 363), § 1, favorably reported by the Insurance and Real Estate Committee, includes similar provisions on the return of health care provider payments, but shortens the period from 18 to 12 months.

§ 4 — EXCHANGE ENROLLMENT WORKING GROUP

Establishes a working group to study and make legislative recommendations on developing a process for individuals and small businesses to directly enroll in health plans offered through Access Health CT

By July 1, 2025, the bill requires the Insurance and Real Estate Committee chairpersons, or their designees, to convene a working group to study and make legislative recommendations on designing and implementing a process for individuals and small businesses to directly enroll in qualified health plans through Access Health CT.

In doing the study, the working group must consider the following:

1. applicable privacy and security laws;

2. appropriate enrollee disclosure requirements, including qualifying financial assistance resources for individuals and small businesses, such as tax credits, reduced out-of-pocket costs,

and potential income tax implications;

3. necessary federal compliance measures;

4. measures to ensure the exchange has access to enrollment and eligibility information for oversight and compliance with federal and state reporting requirements; and

5. measures to provide individuals and small businesses with help from certified enrollment experts.

EFFECTIVE DATE: Upon passage

Membership and Appointments

The working group must consist of the following members:

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

2. an Access Health CT representative;

3. Access Health CT's board of directors' chairperson and chief executive officer, or their designees;

4. the insurance and social services commissioners, or their designees;

5. a representative of the governor's office;

6. the Office of Policy and Management (OPM) secretary, or his designee; and

7. one representative from each health carrier that offers qualified health plans through Access Health CT.

The Insurance and Real Estate Committee chairpersons must appoint the working group members within 30 days after the bill passes and fill any vacancies. The committee's administrative staff must serve in that capacity for the working group.

Reporting

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

§ 5 — INSURANCE PREMIUMS TAX WORKING GROUP

Establishes an 11-member working group to study and make legislative recommendations to lower the state's insurance premiums tax

By July 1, 2025, the bill requires the Insurance and Real Estate Committee chairpersons, or their designees, to convene an 11-member working group to study and make legislative recommendations to lower the insurance premiums tax and any positive economic impact that lowering those taxes may have on the state.

EFFECTIVE DATE: Upon passage

Membership and Appointments

The working group must consist of the following members:

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

2. the OPM secretary and the Revenue Services and Economic and Community Development commissioners, or their designees.

Additionally, the Insurance and Real Estate Committee chairpersons must appoint four members to the working group, one each representing the governor's office, an association of health plans, an insurance association in the state, and Connecticut businesses. The chairpersons must make the initial appointments by 30 days after the bill passes and fill any vacancies.

The committee's administrative staff must serve in that capacity for the working group.

Reporting

The working group must report its findings and legislative

recommendations to the Insurance and Real Estate Committee by February 1, 2026. It terminates on that date or when it submits the report, whichever is later.

§ 6 — FEASIBILITY STUDY OF NONPROFIT ENTITIES POOLING LIABILITY INSURANCE POLICIES

Requires the insurance commissioner to study the feasibility of allowing nonprofit entities to pool liability insurance policies and establishing a captive insurer to insure the pool's risk

The bill requires the insurance commissioner to study the feasibility of:

1. allowing one or more nonprofit entities to pool their liability insurance policies, including general and automobile liability insurance; and

2. establishing a captive insurance company to insure the risk of such a pool.

The commissioner must report the study's findings to the Insurance and Real Estate Committee by February 1, 2026.

EFFECTIVE: Upon passage

Background — Related Bill

sSB 1322 (File 733), § 1, favorably reported by the Insurance and Real Estate, Judiciary, and Appropriations committees, includes identical provisions.

§ 7 — STUDY OF HOMEOWNERS INSURANCE PRACTICES ON REPAIRS OR MODIFICATIONS TO RESIDENTIAL PROPERTIES

Requires the insurance commissioner to study homeowners insurance practices requiring repairs or modifications as a condition of coverage

The bill requires the insurance commissioner to study homeowners insurance practices that require policyholders to make repairs or modifications to their residential properties as a condition of granting or maintaining coverage.

The study must examine the frequency and nature of these practices, any financial impact on the policyholders, the required modifications'

reasonableness and necessity, and related practices in other states.

The commissioner must report the study's findings to the Insurance and Real Estate Committee by February 1, 2026.

EFFECTIVE: Upon passage

Background — Related Bill

sSB 1322 (File 733), § 2, favorably reported by the Insurance and Real Estate, Judiciary, and Appropriations committees, includes identical provisions.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 9 Nay 4 (03/11/2025)