OLR Bill Analysis

sSB 10

AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION.

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SUMMARY

This bill contains provisions on a variety of health insurance topics, including the following:

1. mental health parity compliance and enforcement,
2. rebuttable presumption of the medical necessity of a health care service going through utilization review,
3. the use of artificial intelligence instead of a clinical peer during adverse determination reviews,
4. the use of step therapy protocols for certain prescription drugs,
5. site neutral provider reimbursement rules for outpatient services,
6. health insurance rate review criteria and process, and
7. reimbursements for medically necessary general anesthesia and ancillary services.

A section-by-section analysis follows below.

EFFECTIVE DATE: January 1, 2026, except as specified below.

§§ 1–4 — MENTAL HEALTH PARITY

Requires health carriers to annually file a mental health parity compliance certification with the insurance commissioner, makes public a carrier's compliance with mental health parity requirements, establishes the parity advancement account in the General Fund, and allows the insurance commissioner to impose civil penalties and late fees on carriers who fail to comply with mental health parity requirements

Health Carrier Mental Health Parity Compliance Certification (§ 1)

The bill requires a health carrier (e.g., insurer or HMO), beginning by March 1, 2026, to certify annually to the insurance commissioner for the prior year that the carrier reviewed its administrative practices for compliance with state and federal mental health and substance use disorder benefit requirements. The certification must state whether or not the carrier's review found it complied with the requirements. If it did not comply, the certification must identify each non-compliant

practice and actions the carrier will take to come into compliance. The carrier's chief executive and chief medical officers must sign the certification.

By law, health carriers must report annually to the insurance commissioner on their compliance with state and federal mental health and substance use disorder benefit parity requirements (CGS § 38a-477ee). Parity means that a policy's mental health and substance use disorder benefits, including nonquantitative treatment limitations, are applied in a way that is comparable to, and not more stringent than, the way in which the policy treats medical and surgical benefits.

Public Disclosure of Health Carrier's Parity Compliance (§ 2)

The bill makes a health carrier's reported compliance with parity requirements public. By law, after the carriers annually report to the insurance commissioner on their compliance with mental health and substance use disorder parity requirements, the commissioner must report to the Insurance and Real Estate Committee. Current law prohibits the commissioner from naming the carriers in his reports and requires that he not make the carriers' identities public.

The bill eliminates the requirements that the (1) commissioner's annual report on health carriers' compliance with mental health parity laws not name or identify the carriers and (2) carriers' names and identities be confidential and not made public by the commissioner.

Parity Advancement Account (§ 3)

The bill establishes the "parity advancement account" as a separate, nonlapsing General Fund account that must contain money required to be deposited in it as well as any public or private donations.

Beginning with FY 26, the Insurance Department must spend the account funds on enforcing state and federal mental health and substance use disorder benefit reporting requirements, conducting consumer education, and other initiatives that support mental health parity on behalf of consumers.

Mental Health Parity Enforcement, Penalties, and Late Fees (§ 4)

Penalties and Expenses. The bill allows the insurance commissioner to impose civil penalties on a health carrier that fails to comply with the bill's mental health parity compliance certification requirements or the state and federal mental health and substance use disorder benefit reporting requirements (see § 1 above). The penalty must be up to $100 per member covered under the carrier's health insurance policy, capped at $1 million annually. (Under current law, failure to comply may result in a penalty of up to $15,000 (CGS § 38a-2).)

Before imposing a penalty, the commissioner must allow the carrier a hearing in accordance with the Uniform Administrative Procedure Act. The commissioner may also order the carrier to pay the commissioner reasonable expenses for any proceedings held.

The bill allows the commissioner to waive a civil penalty if the (1) carrier's violation was due to reasonable cause and not willful neglect or (2) carrier corrected noncompliance within 30 days after filing a certification noting the noncompliance.

Late Fees. The bill also requires the commissioner to charge a $100 per day late fee to any carrier that fails to timely file any related mental health parity data, report, certification, or other required information. If a carrier files incomplete information, the commissioner must notify the carrier of what is missing and the date by which the carrier must provide it. The commissioner must charge a $100 per day late fee to a carrier that does not meet the set due date.

Account Deposits. Under the bill, the insurance commissioner must deposit all penalties and late fees received in the General Fund's parity advancement account, which the bill establishes (see § 3 above).

EFFECTIVE DATE: October 1, 2025, except for the provision establishing the parity advancement account, which is effective upon passage.

§§ 5 & 6 — MEDICAL NECESSITY REBUTTABLE PRESUMPTION

Establishes a rebuttable presumption that a health care service going through utilization review is medically necessary if ordered by a health care professional acting within his or her scope of practice

The bill establishes a rebuttable presumption that a health care service that is undergoing utilization review is medically necessary if ordered by a health care professional acting within his or her scope of practice. ("Utilization review" is a process to determine if a service is covered under the health benefit plan. It evaluates the medical necessity, appropriateness, efficacy, or efficiency of health care services, health care procedures, or health care settings, and includes prospective, concurrent, or retrospective review (CGS § 38a-591a(39).)

Under the bill, a utilization review company has the burden of proving the health care service under review is not medically necessary (§ 5). With respect to appeals of utilization review adverse determinations (e.g., denials) that were based on medical necessity, a health carrier may rebut the presumption by reasonably substantiating to the clinical peer (e.g., health care professional) reviewing the adverse determination that the service is not medically necessary (§ 6).

§ 5 — ARTIFICIAL INTELLIGENCE

Prohibits health carriers from using artificial intelligence or other algorithms instead of a clinical peer to evaluate the clinical appropriateness of an adverse determination

The bill prohibits health carriers from using artificial intelligence or other algorithms instead of a clinical peer to evaluate the clinical appropriateness of an adverse determination resulting from a utilization review.

By law, and under the bill, "artificial intelligence" is (1) a set of techniques, including machine learning, designed to approximate a cognitive task or (2) an artificial system that meets certain criteria. These criteria are as follows:

1. performs tasks under varying and unpredictable circumstances without significant human oversight or can learn from experience and improve performance when exposed to data sets;

2. is developed in any context, including software or physical hardware, and solves tasks requiring human-like perception, cognition, planning, learning, communication, or physical action; or

3. is designed to (a) think or act like a human, including a cognitive architecture or neural network, or (b) act rationally, including an intelligent software agent or embodied robot that achieves goals using perception, planning, reasoning, learning, communication, decision-making, or action (CGS § 51-10e).

§§ 7 & 8 — STEP THERAPY RESTRICTIONS

Prohibits health carriers from requiring the use of step therapy for prescription drugs used to treat a mental or behavioral health condition or a disabling or life-threatening chronic disease or condition; for other conditions, reduces how long a carrier can require an insured to use step therapy from 30 to 20 days

The bill limits a health carrier's use of step therapy. Step therapy is a prescription drug protocol that generally requires patients to try less expensive drugs before higher-cost drugs.

The bill prohibits certain individual and group health insurance policies or contracts from requiring the use of step therapy for (1) drugs used to treat a mental or behavioral health condition or (2) a disabling or life-threatening chronic disease or condition, as long as the drug complies with approved Food and Drug Administration indications. (The bill does not define "disabling or life-threatening chronic disease or condition.") Current law prohibits health carriers from requiring the use of step therapy for drugs used to treat (1) stage IV metastatic cancer (indefinitely) or (2) schizophrenia, major depressive disorder, or bipolar disorder (until January 1, 2027).

For drugs prescribed for other conditions, the bill reduces how long a carrier can require an insured to use step therapy from 30 to 20 days.

Under the bill, as under existing law, a patient's provider can deem step therapy clinically ineffective for the patient (immediately for the prohibited conditions or at the end of the waiting period for other conditions), at which point the carrier must cover the drugs prescribed

by the provider, as long as they are covered under the insurance policy or contract. If the provider does not consider the step therapy regimen to be ineffective or does not request an override as the law allows, the regimen may be continued.

The bill applies to individual and group health insurance policies or contracts that provide coverage for prescription drugs and are delivered, issued, renewed, amended, or continued by an insurer, hospital or medical service corporation, health care center (i.e. HMO), or other entity.

§ 9 — SITE NEUTRAL PROVIDER REIMBURSEMENT

Requires health carriers and preferred provider networks that contract with heath care providers to pay equal reimbursement rates for certain outpatient services to all providers in a geographic area and regardless of the facility where the services are provided

The bill requires health carriers and preferred provider networks that enter into, renew, or amend a contract with a health care provider on or after July 1, 2026, to include in the contract a provision requiring equal reimbursement rates for certain covered outpatient services:

1. for all providers in the same geographic region (as determined by the insurance commissioner), regardless of the provider's employer or affiliation, if the services are reimbursed on a fee-for-services basis or as a standardized bundle of benefits (e.g., per diagnosis, condition, or procedure) and

2. regardless of the facility where the services are provided.

The bill applies to covered outpatient services that use a current procedural terminology evaluation and management (CPT E/M) code, current procedural terminology assessment and management (CPT A/M) code, or drug infusion code.

Additionally, the bill requires the (1) contracts to include a conspicuous statement that they comply with the bill's provisions and (2) insurance commissioner to adopt implementing regulations.

EFFECTIVE DATE: July 1, 2026

§§ 10 – 16 — HEALTH INSURANCE RATE REVIEW PROCESS

Prohibits health insurance rates from being unaffordable, sets a rate review process and timeline, requires the insurance commissioner to hold public hearings on each rate filing, allows the health care advocate and attorney general to be parties to a rate filing hearing, and requires the insurance commissioner to adopt regulations

The bill revises the state's rate review process for health insurance policies and contracts issued by health carriers (e.g., insurers, HMOs, and other entities) that are required to file rates with the insurance commissioner. By law, rates cannot be excessive, inadequate, or unfairly discriminatory. The bill also prohibits rates from being unaffordable. It sets a timeline for the rate review process, and requires the insurance commissioner to (1) hold public hearings on each filing and (2) adopt implementing regulations.

Rate Review Process (§§ 15 & 16)

Beginning on January 1, 2026, the bill requires health carriers to file rates with the commissioner at least 120 days before their proposed effective date. Carriers must include with the rate filing an actuarial memorandum certified by an actuary attesting that the rates comply with state and federal laws and are not excessive. The Insurance Department must post (and update) rate filings on its website within three days after receiving them and allow the public at least 30 days to submit written comments on the filings. The posting must include the date the public comment period ends and instructions for submitting comments.

After the public comment period ends, the insurance commissioner must hold a public hearing on each filing. He must determine the hearing date within five business days after posting a filing online; conspicuously post the hearing date, time, and place online; notify the carrier of the hearing; and hold the hearing before the rate's proposed effective date at a place and time that is convenient for the public.

Under the bill, the healthcare advocate, attorney general, or both may be parties to a rate filing public hearing. They must be given access to the Insurance Department's rate filing records, and department staff involved in reviewing the filings must cooperate with them. The healthcare advocate and attorney general may (1) summon and examine

under oath any witnesses deemed necessary for their review of a rate filing and (2) require the health carrier, its holding or parent company, or its subsidiary to produce records reasonably related to the filing.

The bill prohibits the commissioner from approving a rate that is excessive, inadequate, unfairly discriminatory, or unaffordable (see below). Under the bill, the commissioner must conduct an actuarial review of each filing to determine if the proposed rates were developed using methodologies and assumptions that are actuarially sound and comply with actuarial standards. Within 30 days after the public hearing, the commissioner must issue a written decision to approve, disapprove, or modify the rate filing. The decision must include the factors used to reach the decision. The commissioner must post a decision on the department's website within two days after issuing it.

Excessive, Inadequate, Unfairly Discriminatory, and Unaffordable Definitions

Under the bill, a rate is "excessive" if it is unreasonably high for the insurance provided in relation to the underlying risks and costs after considering the following:

1. the filer's experience;
2. the filer's past and projected costs, including commissions;
3. any transfers of funds to the filer's holding or parent company, subsidiary, or affiliate;
4. the filer's rate of return on assets or profitability, as compared to similar filers;
5. a reasonable margin for profit and contingencies;
6. public comments received on the filing; and
7. other factors the commissioner deems relevant.

A rate is "inadequate" if it is unreasonably low for the insurance provided in relation to the underlying risks and costs and its continued

use would endanger the filer's solvency.

A rate is "unfairly discriminatory" if the premium charged for a classification is not reasonably related to the underlying risks and costs, resulting in different premiums for insureds with similar risks and costs.

A rate is "unaffordable" if the insurance commissioner determines it is inconsistent with (1) the Connecticut Health Affordability Index (CHAI) that the Office of Health Strategy (OHS) and state comptroller commission or (2) another metric the insurance and OHS commissioners designate. (The CHAI measures the impact of healthcare costs, including premiums and out-of-pocket expenses, on a household's ability to afford all basic needs, like housing, transportation, child care, and groceries. It serves as a tool to help policymakers understand the real costs of healthcare.)

§§ 17 & 18 — REIMBURSEMENT FOR GENERAL ANESTHESIA

Prohibits health insurance policies from imposing (1) arbitrary time limits on reimbursement for medically necessary general anesthesia or (2) unilateral arbitrary limitations on reimbursement for medically necessary ancillary services

The bill prohibits certain individual and group health insurance policies that cover general anesthesia from (1) imposing arbitrary time limits on reimbursement for general anesthesia during a medically necessary procedure or (2) denying, reducing, terminating, or not providing reimbursement for general anesthesia solely because its duration exceeded the insurer's predetermined time limit for the care. It also prohibits the policies from imposing unilateral arbitrary limitations on reimbursement for medically necessary ancillary services.

The bill requires the attending board-certified anesthesiologist to determine the medical necessity of general anesthesia during a medical procedure.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2026, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Related Bills

SB 11 (§§ 10 & 11), favorably reported by the Human Services Committee, includes the same requirements for medically necessary general anesthesia and ancillary services reimbursements as this bill.

SB 1253 (File 282), favorably reported by the Insurance and Real Estate Committee, allows the insurance commissioner to reduce a health carrier's individual or small employer group health insurance rate filing request by up to two percentage points if the carrier's average approved premium rate increase exceeded the state's health care cost growth benchmark in each of the previous two plan years.

COMMITTEE ACTION

Insurance and Real Estate Committee

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