OLR Bill Analysis

sSB 10 (File 419, as amended by Senate "A")*

AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION.

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SUMMARY

This bill makes various changes in laws related to the following topics, which primarily relate to health insurance:

1. mental health parity compliance and enforcement,
2. the use of step therapy protocols for certain prescription drugs,
3. health insurance premium rate requests,

4. coverage for general anesthesia, and

5. facility fee limits.

A section-by-section analysis follows below.

*Senate Amendment "A" removes provisions on (1) a rebuttable presumption of the medical necessity of a health care service under utilization review; (2) the use of artificial intelligence during adverse determination reviews; (3) site neutral provider reimbursement rules for outpatient services; and (4) health insurance rate review criteria and processes (e.g., prohibiting unaffordable rates). The amendment also adds provisions (1) allowing the insurance commissioner to reduce health insurance premium rate requests in certain circumstances (§§ 6 & 7) and (2) on facility fee limits (§ 10). Additionally, it revises the mental health parity compliance provisions by (1) eliminating the creation of a General Fund parity advancement account; (2) allowing the insurance commissioner to hire independent experts to help with reviewing violations; and (3) capping aggregate penalties and late fees at $625,000. It revises the step therapy provisions by, among other things, (1) eliminating a reduction in how long a health carrier can require an insured to use step therapy and (2) prohibiting step therapy for prescription drugs used to treat multiple sclerosis or rheumatoid arthritis, rather than disabling or life-threatening chronic diseases. It delays, by one year, the effective date of the provision allowing the commissioner to reduce health insurance rate requests (§§ 6 & 7). Lastly, it revises provisions on coverage for general anesthesia by removing reference to ancillary services generally.

EFFECTIVE DATE: January 1, 2026, except October 1, 2025, for the mental health parity compliance-related provisions (§§ 1-3) and January 1, 2027, for the health insurance rate request provisions (§§ 6 & 7).

§§ 1–3 — MENTAL HEALTH PARITY COMPLIANCE

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; authorizes the insurance commissioner to impose civil penalties and late fees on carriers who fail to comply with mental health parity requirements and to engage certain independent experts to help with compliance reviews

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 calendar 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 the carrier was not compliant, the certification must identify each non-compliant practice and action the carrier will take to comply.

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 covers medical and surgical benefits.

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

The bill makes a health carrier's reported compliance or noncompliance with parity requirements public information. By law, upon receipt of the carriers' annual reports, the insurance commissioner must submit them to the Insurance and Real Estate Committee.

Current law prohibits the commissioner from naming or identifying the carriers in his submission to the committee and requires him to keep the carriers' identities confidential. The bill eliminates this prohibition and requirement and in doing so makes the carriers' names and identities public information.

Mental Health Parity Enforcement, Penalties, and Late Fees (§ 3)

Penalties and Expenses. The bill authorizes 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 (see § 1 above), state and federal mental health and substance use disorder benefit reporting requirements, or other state and federal mental health parity laws. Under the bill, the penalty must be up to $100 per covered member or beneficiary under the carrier's health insurance policy, capped at a total of $625,000 annually. (Currently, failure to comply may result in a penalty of up to $15,000 under the existing general penalty (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 any 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, capped at a total of $625,000. 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, beginning from that due date, but capped at a total of $625,000.

Account Deposits. Under the bill, the insurance commissioner must deposit all penalties and late fees received in the General Fund.

Consultants. The bill allows the commissioner to hire a health policy research organization or other independent expert as needed to help in reviewing violations of state mental health parity requirements (i.e. nonquantitative treatment limitations) and federal mental health parity laws.

§§ 4 & 5 — STEP THERAPY RESTRICTIONS

Prohibits health carriers from requiring the use of step therapy for prescription drugs used to treat multiple sclerosis or rheumatoid arthritis; removes the sunset date for the prohibition on the use of step therapy for prescription drugs used to treat schizophrenia, major depressive disorder, or bipolar disorder

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.

Specifically, the bill prohibits certain individual and group health insurance policies or contracts from requiring the use of step therapy for drugs used to treat multiple sclerosis or rheumatoid arthritis, as long as the drug complies with approved Food and Drug Administration indications. Additionally, the bill makes permanent a prohibition on the use of step therapy for drugs used to treat schizophrenia, major depressive disorder, or bipolar disorder. Under current law, this prohibition sunsets on January 1, 2027. The bill removes the sunset date.

Existing law, unchanged by the bill, prohibits health carriers from requiring the use of step therapy for drugs used to treat stage IV metastatic cancer. It allows the use of step therapy for any drug prescribed for a non-prohibited condition, but caps how long a carrier can require an insured to use step therapy to 30 days. It also allows a provider to 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 drug prescribed by the provider if it is covered under the insurance policy or contract.

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.

§§ 6 & 7 — REDUCING HEALTH INSURANCE RATE REQUESTS

Beginning January 1, 2027, allows the insurance commissioner to reduce a health carrier's individual or small employer group health insurance rate request by up to two percentage points if the carrier's average approved rate increase exceeded the state's health care cost growth benchmark in each of the two most recent years for which benchmark data is available

Beginning January 1, 2027, the bill allows the insurance commissioner to reduce a health carrier's individual or small employer group health insurance rate 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 two most recent plan years for which benchmark data is available. This reduction is in addition to any other rate reduction allowed by law.

Existing law requires health carriers to file premium rates for individual and small employer group health insurance policies with the Insurance Department, which must review the rate requests to ensure they are not excessive, inadequate, or unfairly discriminatory. "Small employer" groups are those covering up to 50 employees.

By law, the Office of Health Strategy (OHS) develops the health care cost growth benchmark. OHS set Connecticut's benchmark with a growth target of 3.4% for 2021; 3.2% for 2022; and 2.9% for 2023, 2024, and 2025. OHS subsequently adjusted the 2024 benchmark for inflation, setting it at 4.0%. (The office is in the process of setting the benchmark for the next five years.)

Background — Related Bill

sSB 1253 (File 282), favorably reported by the Insurance and Real Estate Committee, contains similar provisions.

§§ 8 & 9 — REIMBURSEMENT FOR GENERAL ANESTHESIA

Prohibits certain health insurance policies from imposing unilateral arbitrary limitations on reimbursement for general anesthesia

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 failing to

provide reimbursement for general anesthesia solely because its duration exceeded the insurer's predetermined time limit for the care.

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 Bill

SB 11 (§§ 10 & 11) (File 420), favorably reported by the Human Services, Judiciary, and Appropriations committees, includes requirements for medically necessary general anesthesia and ancillary services reimbursements.

§ 10 — FACILITY FEE LIMITS

Reinstates a provision that makes it an unfair trade practice for a hospital, health system, or hospital-based facility to violate facility fee limits

The bill reinstates a provision, repealed in 2023, that makes it an unfair trade practice to violate facility fee limits (see *Background — Connecticut Unfair Trade Practices Act (CUTPA)*). Existing law also allows OHS to impose civil penalties of up to $1,000 for certain violations of these fee limits.

By law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee.

Existing law limits when hospitals, health systems, and hospital-based facilities may charge facility fees for outpatient services provided off-site from a hospital campus. The law also prohibits hospitals or health systems from charging facility fees for certain on-campus outpatient procedures that are not performed in the emergency

department. Among other limits for off-site outpatient services, existing law generally prohibits hospitals, health systems, and hospital-based facilities from charging facility fees for these services that use a current procedural terminology evaluation and management (CPT E/M) code or CPT assessment and management (CPT A/M) code. These limits do not apply to Medicare and Medicaid patients, patients receiving services under a workers' compensation plan, or freestanding emergency departments.

Background — Connecticut Unfair Trade Practices Act (CUTPA)

By law, CUTPA prohibits businesses from engaging in unfair and deceptive acts or practices. It allows the consumer protection commissioner, under specified procedures, to issue regulations defining an unfair trade practice, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $10,000, impose civil penalties of up to $5,000**,** enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and up to $25,000 for a restraining order violation.

COMMITTEE ACTION

Insurance and Real Estate Committee

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

Judiciary Committee

Joint Favorable
Yea 28 Nay 11 (05/06/2025)

Appropriations Committee

Joint Favorable
Yea 37 Nay 11 (05/12/2025)