



General Assembly

Amendment

January Session, 2025

LCO No. 8138



Offered by:

SEN. LOONEY, 11th Dist.

SEN. DUFF, 25th Dist.

SEN. CABRERA, 17th Dist.

To: Subst. Senate Bill No. 10

File No. 419

Cal. No. 241

"AN ACT CONCERNING HEALTH INSURANCE AND PATIENT PROTECTION."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

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

4 (1) "Health carrier" has the same meaning as provided in section 38a-
5 1080 of the general statutes; and

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

9 (b) (1) Not later than March 1, 2026, and annually thereafter, each
10 health carrier shall file a certification with the Insurance Commissioner
11 for the immediately preceding calendar year, certifying that such health
12 carrier completed a review of such health carrier's administrative

13 practices for compliance with the state and federal mental health and
14 substance use disorder benefit reporting requirements pursuant to
15 sections 38a-477ee, as amended by this act, 38a-488c, 38a-488d, 38a-514c,
16 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this act, and 38a-
17 544 of the general statutes, as amended by this act, and the provisions
18 of the federal Paul Wellstone and Pete Domenici Mental Health Parity
19 and Addiction Equity Act of 2008, P.L. 110-343, as amended from time
20 to time, and regulations adopted thereunder.

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 October 1, 2025*) (a) (1) The commissioner, after
57 providing an opportunity for a hearing in accordance with chapter 54 of
58 the general statutes, may impose a civil penalty on any health carrier of
59 not more than one hundred dollars with respect to each participant or
60 beneficiary covered under a health insurance policy of such health
61 carrier, provided such penalty shall not exceed an aggregate amount of
62 one million dollars annually, for such health carrier's failure to comply
63 with (A) the certification requirements pursuant to the provisions of
64 section 1 of this act, (B) the state and federal mental health and substance
65 use disorder benefit reporting requirements identified in subdivision (1)
66 of subsection (b) of section 1 of this act, or (C) any other requirement
67 pursuant to sections 38a-477ee, as amended by this act, 38a-488c, 38a-
68 488d, 38a-514c, 38a-514d, 38a-488a, 38a-514, 38a-510, as amended by this
69 act, and 38a-544 of the general statutes, as amended by this act, and the
70 provisions of the federal Paul Wellstone and Pete Domenici Mental
71 Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as
72 amended from time to time, and regulations adopted thereunder.

73 (2) The commissioner may order the payment of such reasonable
74 expenses as may be necessary to compensate the commissioner in
75 conjunction with any proceedings under this section, which shall be

76 dedicated to the enforcement and implementation of the state and
77 federal mental health parity laws and regulations adopted thereunder.

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

85 (2) For any health carrier that files any incomplete data, report,
86 certification or other information required by the provisions of section
87 38a-477ee of the general statutes, as amended by this act, and section 1
88 of this act, the commissioner shall provide notice to such health carrier
89 of such incomplete filing that includes (A) a description of such data,
90 report, certification or other information that is incomplete and any
91 additional data that is needed to consider such filing complete, and (B)
92 the date by which such health carrier is required to provide such data.
93 The commissioner shall impose a late fee on such health carrier of one
94 hundred dollars per day, commencing from the date identified by the
95 commissioner pursuant to subparagraph (B) of this subdivision.

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

102 (d) All civil penalties and late fees received by the commissioner
103 pursuant to this section shall be deposited in the General Fund.

104 (e) The commissioner may engage the services of any health policy
105 research organization or any other independent expert as the
106 commissioner deems necessary to assist the commissioner in the review

107 of any violation of the nonquantitative treatment limitations
108 requirements pursuant to section 38a-477ee of the general statutes, as
109 amended by this act, and the provisions of the federal Paul Wellstone
110 and Pete Domenici Mental Health Parity and Addiction Equity Act of
111 2008, P.L. 110-343, as amended from time to time, and regulations
112 adopted thereunder.

113 Sec. 4. Section 38a-510 of the general statutes is repealed and the
114 following is substituted in lieu thereof (*Effective January 1, 2026*):

115 (a) No insurance company, hospital service corporation, medical
116 service corporation, health care center or other entity delivering, issuing
117 for delivery, renewing, amending or continuing an individual health
118 insurance policy or contract that provides coverage for prescription
119 drugs may:

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

123 (2) Require, if such insurance company, hospital service corporation,
124 medical service corporation, health care center or other entity uses step
125 therapy for such drugs, the use of step therapy (A) for any prescribed
126 drug for longer than thirty days, (B) for a prescribed drug for [cancer
127 treatment for an insured who has been diagnosed with stage IV
128 metastatic cancer provided] the treatment of a disability, as defined in
129 42 USC 12102, as amended from time to time, provided such disability
130 is expected to last for a continuous period of not less than five years, as
131 determined by the insured's health care provider, and such prescribed
132 drug is in compliance with approved federal Food and Drug
133 Administration indications, or (C) for [the period commencing January
134 1, 2024, and ending January 1, 2027, inclusive, for the treatment of
135 schizophrenia, major depressive disorder or bipolar disorder, as defined
136 in the most recent edition of the American Psychiatric Association's
137 "Diagnostic and Statistical Manual of Mental Disorders"] a prescribed
138 drug for the treatment of a mental or behavioral health condition,

139 provided such prescribed drug is in compliance with approved federal
140 Food and Drug Administration indications.

141 (3) At the expiration of the time period specified in subparagraph (A)
142 of subdivision (2) of this subsection or for a prescribed drug described
143 in subparagraph (B) or (C) of subdivision (2) of this subsection, an
144 insured's treating health care provider may deem such step therapy
145 drug regimen clinically ineffective for the insured, at which time the
146 insurance company, hospital service corporation, medical service
147 corporation, health care center or other entity shall authorize
148 dispensation of and coverage for the drug prescribed by the insured's
149 treating health care provider, provided such drug is a covered drug
150 under such policy or contract. If such provider does not deem such step
151 therapy drug regimen clinically ineffective or has not requested an
152 override pursuant to subdivision (1) of subsection (b) of this section,
153 such drug regimen may be continued. For purposes of this section, "step
154 therapy" means a protocol or program that establishes the specific
155 sequence in which prescription drugs for a specified medical condition
156 are to be prescribed.

157 (b) (1) Notwithstanding the [sixty-day] thirty-day period set forth in
158 subparagraph (A) of subdivision (2) of subsection (a) of this section,
159 each insurance company, hospital service corporation, medical service
160 corporation, health care center or other entity that uses step therapy for
161 such prescription drugs shall establish and disclose to its health care
162 providers a process by which an insured's treating health care provider
163 may request at any time an override of the use of any step therapy drug
164 regimen. Any such override process shall be convenient to use by health
165 care providers and an override request shall be expeditiously granted
166 when an insured's treating health care provider demonstrates that the
167 drug regimen required under step therapy (A) has been ineffective in
168 the past for treatment of the insured's medical condition, (B) is expected
169 to be ineffective based on the known relevant physical or mental
170 characteristics of the insured and the known characteristics of the drug
171 regimen, (C) will cause or will likely cause an adverse reaction by or

172 physical harm to the insured, or (D) is not in the best interest of the
173 insured, based on medical necessity.

174 (2) Upon the granting of an override request, the insurance company,
175 hospital service corporation, medical service corporation, health care
176 center or other entity shall authorize dispensation of and coverage for
177 the drug prescribed by the insured's treating health care provider,
178 provided such drug is a covered drug under such policy or contract.

179 (c) Nothing in this section shall (1) preclude an insured or an
180 insured's treating health care provider from requesting a review under
181 sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of
182 section 38a-492i.

183 Sec. 5. Section 38a-544 of the general statutes is repealed and the
184 following is substituted in lieu thereof (*Effective January 1, 2026*):

185 (a) No insurance company, hospital service corporation, medical
186 service corporation, health care center or other entity delivering, issuing
187 for delivery, renewing, amending or continuing a group health
188 insurance policy or contract that provides coverage for prescription
189 drugs may:

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

193 (2) Require, if such insurance company, hospital service corporation,
194 medical service corporation, health care center or other entity uses step
195 therapy for such drugs, the use of step therapy (A) for any prescribed
196 drug for longer than thirty days, (B) for a prescribed drug for [cancer
197 treatment for an insured who has been diagnosed with stage IV
198 metastatic cancer provided] the treatment of a disability, as defined in
199 42 USC 12102, as amended from time to time, provided such disability
200 is expected to last for a continuous period of not less than five years, as
201 determined by the insured's health care provider, and such prescribed
202 drug is in compliance with approved federal Food and Drug

203 Administration indications, or (C) for [the period commencing January
204 1, 2024, and ending January 1, 2027, inclusive, for the treatment of
205 schizophrenia, major depressive disorder or bipolar disorder, as defined
206 in the most recent edition of the American Psychiatric Association's
207 "Diagnostic and Statistical Manual of Mental Disorders"] a prescribed
208 drug for the treatment of a mental or behavioral health condition,
209 provided such prescribed drug is in compliance with approved federal
210 Food and Drug Administration indications.

211 (3) At the expiration of the time period specified in subparagraph (A)
212 of subdivision (2) of this subsection or for a prescribed drug described
213 in subparagraph (B) or (C) of subdivision (2) of this subsection, an
214 insured's treating health care provider may deem such step therapy
215 drug regimen clinically ineffective for the insured, at which time the
216 insurance company, hospital service corporation, medical service
217 corporation, health care center or other entity shall authorize
218 dispensation of and coverage for the drug prescribed by the insured's
219 treating health care provider, provided such drug is a covered drug
220 under such policy or contract. If such provider does not deem such step
221 therapy drug regimen clinically ineffective or has not requested an
222 override pursuant to subdivision (1) of subsection (b) of this section,
223 such drug regimen may be continued. For purposes of this section, "step
224 therapy" means a protocol or program that establishes the specific
225 sequence in which prescription drugs for a specified medical condition
226 are to be prescribed.

227 (b) (1) Notwithstanding the [sixty-day] thirty-day period set forth in
228 subparagraph (A) of subdivision (2) of subsection (a) of this section,
229 each insurance company, hospital service corporation, medical service
230 corporation, health care center or other entity that uses step therapy for
231 such prescription drugs shall establish and disclose to its health care
232 providers a process by which an insured's treating health care provider
233 may request at any time an override of the use of any step therapy drug
234 regimen. Any such override process shall be convenient to use by health
235 care providers and an override request shall be expeditiously granted

236 when an insured's treating health care provider demonstrates that the
237 drug regimen required under step therapy (A) has been ineffective in
238 the past for treatment of the insured's medical condition, (B) is expected
239 to be ineffective based on the known relevant physical or mental
240 characteristics of the insured and the known characteristics of the drug
241 regimen, (C) will cause or will likely cause an adverse reaction by or
242 physical harm to the insured, or (D) is not in the best interest of the
243 insured, based on medical necessity.

244 (2) Upon the granting of an override request, the insurance company,
245 hospital service corporation, medical service corporation, health care
246 center or other entity shall authorize dispensation of and coverage for
247 the drug prescribed by the insured's treating health care provider,
248 provided such drug is a covered drug under such policy or contract.

249 (c) Nothing in this section shall (1) preclude an insured or an
250 insured's treating health care provider from requesting a review under
251 sections 38a-591c to 38a-591g, inclusive, or (2) affect the provisions of
252 section 38a-518i.

253 Sec. 6. Subsection (b) of section 38a-481 of the general statutes is
254 repealed and the following is substituted in lieu thereof (*Effective January*
255 *1, 2026*):

256 (b) No rate filed under the provisions of subsection (a) of this section
257 shall be effective until it has been approved by the commissioner in
258 accordance with regulations adopted pursuant to this subsection. The
259 commissioner shall adopt regulations, in accordance with the
260 provisions of chapter 54, to prescribe standards to ensure that such rates
261 shall not be excessive, inadequate or unfairly discriminatory. The
262 commissioner may disapprove such rate if it fails to comply with such
263 standards, except that no rate filed under the provisions of subsection
264 (a) of this section for any Medicare supplement policy shall be effective
265 unless approved in accordance with section 38a-474. If the
266 commissioner determines that a health carrier's average premium rate
267 increase, as approved by the commissioner, exceeded the health care

268 cost growth benchmark established pursuant to section 19a-754g for
269 each of the two most recent plan years for which such health care cost
270 growth benchmark data is available, the commissioner may reduce such
271 health carrier's requested rate filed under the provisions of subsection
272 (a) of this section by not more than two percentage points of such
273 premium rate filed in addition to any other rate reductions authorized
274 under this title.

275 Sec. 7. Subsection (a) of section 38a-513 of the general statutes is
276 repealed and the following is substituted in lieu thereof (*Effective January*
277 *1, 2026*):

278 (a) (1) No group health insurance policy, as defined by the
279 commissioner, or certificate shall be delivered or issued for delivery in
280 this state unless a copy of the form for such policy or certificate has been
281 submitted to and approved by the commissioner under the regulations
282 adopted pursuant to this section. The commissioner shall adopt
283 regulations, in accordance with the provisions of chapter 54, concerning
284 the provisions, submission and approval of such policies and certificates
285 and establishing a procedure for reviewing such policies and
286 certificates. The commissioner shall disapprove the use of such form at
287 any time if it does not comply with the requirements of law, or if it
288 contains a provision or provisions that are unfair or deceptive or that
289 encourage misrepresentation of the policy. The commissioner shall
290 notify, in writing, the insurer that has filed any such form of the
291 commissioner's disapproval, specifying the reasons for disapproval,
292 and ordering that no such insurer shall deliver or issue for delivery to
293 any person in this state a policy on or containing such form. The
294 provisions of section 38a-19 shall apply to such order.

295 (2) No group health insurance policy or certificate for a small
296 employer, as defined in section 38a-564, shall be delivered or issued for
297 delivery in this state unless the premium rates have been submitted to
298 and approved by the commissioner. If the commissioner determines
299 that any small group health insurance carrier's average premium rate
300 increase, as approved by the commissioner, or certificate for a small

301 employer, exceeded the health care cost growth benchmark established
302 pursuant to section 19a-754g for each of the two most recent plan years
303 for which such health care cost growth benchmark data is available, the
304 commissioner may reduce such policy's or certificate's requested
305 premium rate filing under the provisions of subsection (a) of this section
306 by not more than two percentage points of such premium rate filed in
307 addition to any other premium rate reductions authorized under this
308 title. Premium rate filings shall include the information and data
309 required under section 38a-479qqq if the policy is subject to said section,
310 and an actuarial memorandum that includes, but is not limited to,
311 pricing assumptions and claims experience, and premium rates and loss
312 ratios from the inception of the policy. Each premium rate filed on or
313 after January 1, 2021, shall, if the insurer intends to account for rebates,
314 as defined in section 38a-479ooo in the manner specified in section 38a-
315 479rrr, account for such rebates in such manner, if the policy is subject
316 to section 38a-479rrr. As used in this subdivision, "loss ratio" means the
317 ratio of incurred claims to earned premiums by the number of years of
318 policy duration for all combined durations.

319 Sec. 8. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

320 (1) "General anesthesia" has the same meaning as provided in section
321 20-123a of the general statutes; and

322 (2) "Medical necessity" has the same meaning as provided in section
323 38a-482a of the general statutes.

324 (b) No individual health insurance policy providing coverage of the
325 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
326 of the general statutes delivered, issued for delivery, renewed, amended
327 or continued in this state on or after January 1, 2026, that provides
328 coverage for any medically necessary surgical procedure, shall impose
329 unilateral arbitrary limitations on reimbursement for medically
330 necessary ancillary services, including, but not limited to, (1) any
331 arbitrary time limit on reimbursement for general anesthesia provided
332 during any such medically necessary surgical procedure, or (2) any

333 denial, reduction, termination or failure to provide such reimbursement,
334 in whole or in part, for general anesthesia solely because the duration of
335 care exceeded a predetermined time limit as determined by the insurer.

336 Sec. 9. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

337 (1) "General anesthesia" has the same meaning as provided in section
338 20-123a of the general statutes; and

339 (2) "Medical necessity" has the same meaning as provided in section
340 38a-482a of the general statutes.

341 (b) No group health insurance policy providing coverage of the type
342 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
343 the general statutes delivered, issued for delivery, renewed, amended
344 or continued in this state on or after January 1, 2026, that provides
345 coverage for any medically necessary surgical procedure, shall impose
346 unilateral arbitrary limitations on reimbursement for medically
347 necessary ancillary services, including, but not limited to, (1) any
348 arbitrary time limit on reimbursement for general anesthesia provided
349 during any such medically necessary surgical procedure, or (2) any
350 denial, reduction, termination or failure to provide such reimbursement,
351 in whole or in part, for general anesthesia solely because the duration of
352 care exceeded a predetermined time limit as determined by the insurer.

353 Sec. 10. (NEW) (*Effective July 1, 2026*) (a) As used in this section:

354 (1) "Facility fee" has the same meaning as provided in section 19a-
355 508c of the general statutes; and

356 (2) "Self-pay patient" has the same meaning as provided in section
357 17b-341 of the general statutes.

358 (b) (1) Each insurer, health care center, hospital service corporation,
359 medical service corporation, preferred provider network or other entity
360 that enters into, renews or amends a contract with a health care provider
361 on or after July 1, 2026, to provide covered benefits to insureds or

362 enrollees in this state shall include in such contract a provision requiring
 363 such insurer, health care center, hospital service corporation, medical
 364 service corporation, preferred provider network or other entity to
 365 reimburse the contracting health care provider for a covered outpatient
 366 benefit that uses a current procedural terminology evaluation and
 367 management (CPT E/M) code, current procedural terminology
 368 assessment and management (CPT A/M) code or drug infusion code in
 369 an amount equal to one hundred fifty per cent of the nonfacility rate in
 370 the current Medicare physician fee schedule established by the federal
 371 Centers for Medicare and Medicaid Services.

372 (2) No health care provider shall directly or indirectly charge, bill or
 373 otherwise solicit payment for any such outpatient benefit described in
 374 subdivision (1) of this subsection that exceeds one hundred fifty per cent
 375 of the nonfacility rate in the current Medicare physician fee schedule
 376 established by the federal Centers for Medicare and Medicaid Services.
 377 The provisions of this subdivision shall apply to any individual or entity
 378 that provides reimbursement for any such outpatient benefit, including,
 379 but not limited to, self-pay patients and health benefit plans that do not
 380 have an existing contract with such health care provider. No health care
 381 provider shall directly or indirectly charge, bill or otherwise solicit
 382 payment for a facility fee for any such outpatient benefit.

383 (c) The Insurance Commissioner shall adopt regulations, in
 384 accordance with the provisions of chapter 54 of the general statutes, to
 385 implement the provisions of this section."

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>October 1, 2025</i>	New section
Sec. 4	<i>January 1, 2026</i>	38a-510
Sec. 5	<i>January 1, 2026</i>	38a-544
Sec. 6	<i>January 1, 2026</i>	38a-481(b)
Sec. 7	<i>January 1, 2026</i>	38a-513(a)

Sec. 8	<i>January 1, 2026</i>	New section
Sec. 9	<i>January 1, 2026</i>	New section
Sec. 10	<i>July 1, 2026</i>	New section